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TRANSACTIONS

OF THE

THIRTY-SIXTH SESSION

OF THE

HOMOEOPATHIC MEDICAL SOCIETY

OF THE

STATE OF PENNSYLVANIA.

HELD AT WILKESBARRE, SEPTEMBER 25, 26 and 27, 1900.

LANCASTER, PA.:
THE EXAMINER PRINTING HOUSE.
1901.

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Second Vice-President, . R. P. Mercer, M. D., ... Chester.
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Corresponding Secretary, Edward M. Gramm, M. D.,
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- (2 yrs.) Thomas H. Carmichael, M. D., .. Phila.
- (1 yr.) J. W. Coolidge, M. D., ... Scranton.

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Treasurer,		Ella D. Goff, M. D.,	Allegheny.
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	do.	Z. T. Miller, M. D.,	Pittsburg.
	do.	E. M. Gramm, M. D.,	Philadelphia.
	(1 yr.)	B. F. Betts, M. D.,	Philadelphia.
	do.	C. C. Rinehart, M. D.,	Pittsburg.
	do.	W. H. Keim, M. D.,	Philadelphia.

To the Homœopathic Medical Society of the State of Pennsylvania:

Your Committee on Publication herewith presents the Proceedings and Papers of the Thirty-sixth Session of the Society. It will be noticed that a change has been made in the typography of the volume. This has resulted in decreasing its size, as well as the expense of printing. The cost of transmitting each volume to a member has been correspondingly lowered, and it is confidently expected that the saving which has been brought about in both of these items will materially aid in enabling a reduction in the dues to be made, and yet provide sufficient income to carry on the work of the Society as in the past.

Edward M. Gramm, M. D.,
Ella D. Goff, M. D.,
George B. Moreland, M. D.

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TRANSACTIONS

OF THE

THIRTY-SIXTH SESSION

OF THE

Homœopathic Medical Society

OF THE

State of Pennsylvania.

Held at the Y. M. C. A. Building, Wilkesbarre, September 25, 26 and 27, 1900.

The President, C. C. Rinehart, M. D., of Pittsburg, called the meeting to order on the morning of September 25, 1900.

The invocation of Divine Providence was made by the Rev. Dr. Pearce.

Hon. F. M. Nichols, Mayor of Wilkesbarre, greeted the members in the following

ADDRESS OF WELCOME.

Mr. President, Ladies and Gentlemen:

This Convention completes a splendid illustration of that principle in the philosophy of human life I have been taught in precept and experience. Unhesitating resignation to all inevitables is one of the highest virtues in the character of man, and enables him to avoid the loss of friends and mental equilibrium through the promptings of irritation. One of the proverbs used to make clear to us the mean-

ing of resignation is this: "We must take the bitter with the sweet." The interval between this and the Convention of last week is so short that I could not fail to observe in the incident full proof of the truth of this saying.

On Tuesday, the 18th day of this month, I was honored with the high privilege of extending greetings of welcome to most distinguished representatives of that branch of the medical profession on which you did not grow and to which you have never been grafted. The gentlemen present on that occasion compel us to swallow bitter pills, and you, having more respect for the sensibilities of the human palate, prescribe sweet or sugar pills. Rather than disobey the resignation rule, to which I have referred, we take both.

In my address to the allopathic doctors I most severely tried their patience with an extended analysis of the membership of the medical profession of this country. I shall test this Christian virtue in you by giving you my opinion of the doctor in his private and public services.

My first estimate of the services of the doctor in the home was conceived when I was learning the alphabet of the English language. Thus stated, you may not be able to determine the exact period when this original rating entered my mind. Hence I inform you that, in boyhood, I was not favored with extraordinary precociousness. Therefore it is probable that I was not younger than six years of age.

The opinion I then formed as to the grade of nobility occupied by the doctor has never been changed. Of course the mystery in which his calling seemed to be involved has vanished, and, with it, any notion I may have had that he possessed supernatural powers. But the kindness, devotion to duty and high regard for the honor of the profession, which I then observed in the doctor, I have never found wanting in him since.

I wish I could, in a manner satisfactory to myself, give you a description of that good man whose presence and services in father's family gave me my first idea of the doctor. None of the photographs placed in the album of my memory during childhood are more distinct or oftener looked at by me than that of Dr. Mills.

In the small village and large scope of agricultural country where he practiced no competitor, striving to gain his patronage, gave him anxiety. Hence his faithfulness to patients was prompted alone by sense of duty and a desire to relieve his fellow-beings in distress. Among his immediate neighbors his professional calls were made on foot, and those summoned by his other patrons in a sulky now

most rarely among the equipments of the doctor. Well, I remember the medicine bag carried in this vehicle, and the pearl-handled knife on the tip end of the blade of which he measured and apportioned the drugs of his famous powders.

My recollection of the taste of these powders could not be extinguished without total annihilation of my faculty of memory. It was given this lodgment, mainly, because of the method employed to force me to take the powders. In this procedure, many times the doctor co-operated with mother. On such occasions he took charge of my nose, holding it a prisoner between his fat, chubby, soft forefinger and thumb.

Thus treated, I could not avoid swallowing the "nasty stuff." As I recall these incidents in the bitter department of my childhood, I often wonder how the doctor maintained his grip. In those days boys detested the use of pocket handkerchiefs and, therefore, I am quite sure that, many times, the doctor was almost defeated by an abundance of lubrication.

Notwithstanding this most insulting imprisonment of my nose, I never entertained any resentful feelings toward the doctor. He performed the operation so tenderly and was so much amused at my contortions that it was only the bitterness of the medicine that influenced me to resist.

Yes, Doctor Mills was old-fashioned. The light of medical science is much brighter and reveals to us wider fields of knowledge than when he ministered to the sick. But through patience that never tired, kindness, sympathy and devotion never absent from his presence, speech or work, his successes in saving human life, in the dimmer light, were not inferior to those gained in the achievements of the present.

The nobility of the life and faithful and Christian services of Doctor Mills gave me the standard by which I estimate the deserts of doctors devoted to the honor of their noble profession, and earnestly endeavoring to accomplish the highest aims of their sublime mission. Judged by this standard, all whose services and counsel misfortunes and public duties have compelled me to seek have demonstrated their worthiness of the testimonial I have given to the doctor of father's home.

The doctor in government, since I began the official life born at the time of my election to the Mayor's office of this city in 1892, has excited in me, for him, new feelings of admiration. Probably in all the municipalities of this country he is required to render service to

civil government without compensation. The time, skill and labor necessary for the execution of this service, if compensated according to the rates charged individuals for them, would add a very large item of expense to the cost of municipal government. In fairness, the doctor is entitled to this compensation.

The free service demanded of him reduces his opportunities for financial gain, prolongs the life of the people and saves them an enormous amount of expense every year by banishing from their midst conditions which invite and maintain epidemics. The doctor, however, does not allow this failure to give just recognition of the value of his services to cause him to refuse obedience to any sanitary laws requiring him to perform public duties.

In this city all members of the profession most cheerfully discharge every duty imposed upon them in the legislation of our State and local government. No doubt the doctors of all other cities in like manner contribute to the preservation of the public health. Our indebtedness to the medical profession for this service cannot be overestimated.

In spite, however, of the great advance accomplished during the last fifty years in the discovery and application of preventives, suggested in the science of sanitation, a very large number of deaths and much sickness could be avoided annually if the doctors were given wider opportunities to serve in the health departments of public government. 875,521 of our people died during the year 1890. Only 45,507 of this number were due to accidents and injuries. The remainder were caused by the ravages of diseases.

From the attack of these diseases, undoubtedly, at least 100,000 of their victims could have been saved by wiser and more vigilant administration of preventives furnished in cleanliness, isolation, adequate ventilation, wholesome food and pure drinking water. All these sources of safety may be provided by every municipality in the land. Indeed, so far as legislation necessary for this purpose is concerned, they are provided for in all these local governments. But they do not yield the full measure of benefits obtainable because they are not managed by competent and faithful officials.

This loss of the advantages of sanitary conditions cannot be overcome until we recognize the need of placing our health departments under superintendency supplied by learned representatives of the medical profession. Such a policy would more than double the efficiency of this public agency and make it produce the largest measure of protection it is intended to afford.

I have now arrived at the end of all I prepared to say in expressing my opinion of the doctor in private and public life. In all I have said of him, I have been sincere and actuated by a desire to obey the promptings of deep gratitude for his kindness to me, both in the days of my boyhood and in the days of my manhood. Hence, gentlemen, you will justly appreciate the extreme pleasure with which I welcome you to our beloved City.

RESPONSE TO ADDRESS OF WELCOME.

C. C. RINEHART, M. D.

In behalf of the society, I thank you, sir, for your cordial words of welcome, which, if our program is to be believed, is to be supplemented by many other acts of kindness, and, mayhap, some not "nominate in the bond." We are here at the solicitation of the physicians of the North Eastern Pennsylvania Medical Society, and have come to ponder over, and give our experience, concerning the methods for the amelioration of the "ills that flesh is heir to." And it is to be hoped that when we leave your beautiful city we shall be able to say that "it was good to have been here," and that our stock of knowledge has been so much increased that each will find himself better able to treat the sick and wounded than he would have been had he stayed away.

As the flowers of the field stretch their heads to drink in the revivifying dew, and pour forth their fragrance in return, so may we each stand ready to give and receive those words of wisdom that shall make us better physicians and better men and women. Nature has been very kind to the sons of men. In your beautiful valley she has stored away, long ages ago, the sun's power and potency in a supply of fuel that has made your people rich in this world's goods, and has enabled not only your own people, but countless thousands of others, to defy the cold blasts of winter, and in another sense to lay away something for a rainy day. Her beneficence has been manifested in many other directions, not the least of which is the way she has furnished materials for the relief of mankind from the "ills of the flesh." By a law of nature you are able to transmit the heat that has been stored away into steam, electricity, and other forms of motion. By another law of nature we are enabled to cure the sick and relieve the sufferings of humanity. "Similia Similius Curentur" not alone have reference to the cure of the sick by Homœopathic methods, but is a law, in somewhat different phraseology, permeating

all science. Kirschoff, when he announced the law that "all substances in a gaseous state are capable of absorbing just such rays as they are capable of producing," announced the Homœopathic law in physics. When it is said that "no two similar forces can exist together at the same time," we have the Homœopathic law with a different expression.

Whether or not these things have been pertinent as a reply to your kindly welcome, they have given us an opportunity to give a reason for "the faith that is within us."

We believe in Homœopathy, and delight to be called homœopaths; we are glad to be here with you and enjoy your hospitality, and we thank you again and again for your kind and generous welcome.

The Treasurer, Dr. Ella D. Goff, presented a report showing a balance of $1,205,60 in the Treasury.

The President thereupon appointed Drs. J. A. Bullard, I. B. Gilbert and W. J. Martin an auditing committee, which, later, presented the following

REPORT OF THE AUDITING COMMITTEE.

We, the undersigned committee, have examined the accounts of the Treasurer, Dr. Ella D. Goff, and find them correct.

J. A. Bullard, M. D., Chairman.
I. B. Gilbert, M. D.
W. J. Martin, M. D.

On motion, the report was accepted and the Committee discharged with the thanks of the Society.

REPORT OF THE CORRESPONDING SECRETARY.

The Corresponding Secretary presented the following program for the meeting, which was, on motion, adopted:

ORDER OF BUSINESS.

TUESDAY, SEPTEMBER 25, 1900.

Morning Session, 9:30 to 1 o'clock.

1. Call to order.
2. Invocation, Rev. Dr. Pearce.
3. Address of Welcome, Hon. F. M. Nichols.

4. Response.
5. Roll Call. Correction of List of Members.
6. Report of Treasurer. Appointment of Auditing Committee.
7. Report of Corresponding Secretary. Adoption of Program.
8. Report of Trustees.
9. Report of Committees.
   a. Organization, Registration and Statistics, George B. Moreland, M. D., Chairman.
   b. Legislation, H. C. Chisholm, M. D., Chairman.
   c. Publication, Edward M. Gramm, M. D., Chairman.
   d. Hahnemann Monument, W. J. Martin, M. D., Chairman.
10. Report of Delegates to the American Institute of Homœopathy.
11. Report of Delegates to the Delaware State Society.
12. Report of Delegates to the Inter-State Committee of the American Institute of Homœopathy.
13. Report of Delegates to the Maryland State Society.
14. Report of Delegates to the Massachusetts State Society.
15. Report of Delegates to the New Jersey State Society.
16. Report of Delegates to the New York State Society.
17. Report of Delegates to the Ohio State Society.
18. Report of Delegates to the Southern Institute of Homœopathy.
19. Report of Delegates to the West Virginia State Society.
20. Report of Delegates from State Societies and Local Organizations.
21. Report of Necrologist, Thomas L. Bradford, M. D.
22. Report of Auditing Committee.
23. By direction of the Board of Trustees, Dr. W. H. Keim submitted the following amendments to the By-Laws at the last meeting of the Society:

Amend Article V., Section 1, by striking out after the word "directed," on the third line, these words: "Give orders on the Treasurer according to these By-Laws," that the clause may read:

Article V.—Duties of Officers.

Section 1.—The President shall preside at all meetings of the Society. He shall preserve order, appoint all committees unless otherwise directed, and discharge all other duties usually pertaining to a presiding officer, in accordance with the provisions of the Charter and these By-Laws. He shall be, *ex-officio,* a member of all standing committees of the Society. He shall be eligible to two terms in succession.

Amend Article V., Section 7, by striking out after the word "Society," on the third line, and inserting "The Trustees shall have the power to disburse all money belonging to the Society. No money shall be paid from the treasury except upon a written order, drawn on the Treasurer, countersigned by the President and Secretary of the Board of Trustees," that the clause may read:

Sec. 7.—The Trustees shall have general supervision of the business of the Society, hold at least one meeting every year, and make a report at the annual session of the Society. The Trustees shall have the power to disburse all money belonging to the Society. No money shall be paid from the treasury except upon a written order, drawn on the Treasurer, countersigned by the President and Secretary of the Board of Trustees.

Amend Article V., Section 6, by adding after the word "meeting" these words: "The report shall, without being read in open session, be referred to the Publication Committee, and published in full in the Transactions."

Amend Article VI., Section 1, by striking out the word "nine" on the second line, and inserting the word "eleven," that the clause may read:

Article VI.—Meetings.

Section 1. The annual meeting shall be held in the month of September, at eleven A. M., on the days and at the place decided upon at the annual meeting next preceding.

SECTION OF SANITARY SCIENCE.

Trimble Pratt, M. D., Chairman.

Associates.—Drs. A. W. Baily, A. M. Barnes, A. J. Bittner, F. W. Boyer, Mary Brewer, H. M. Bunting, William Cowley, Pemberton Dudley, S. G. Godshall, Silas Griffith, B. W. James, W. H. Keim, W. C. Powell, H. L. Stambach, J. A. Walter, B. K. Wilbur.

Trimble Pratt, M. D., Media. "Sanitary Science."

S. G. Godshall, M. D., Edge Hill. "The Hygiene of the Country School."

Bushrod W. James, M. D., Philadelphia. "Advantages of American Climates and Health Resorts."

R. P. Mercer, M. D., Chester. "Ventilation."

C. S. Middleton, M. D., Philadelphia. "Imperfect Ventilation of Dwellings."

Z. T. Miller, M. D., Pittsburg. "Isn't It Funny?"

W. C. Powell, M. D. Bryn Mawr. "Overwork of Public School Children."

Afternoon Session, 3 to 6 o'clock.

SECTION OF CLINICAL MEDICINE.

A. B. Lichtenwalner, M. D., Chairman.

Associates.—Drs. Mary Branson, T. H. Carmichael, J. H. Closson, I. B. Gilbert, E. M. Gramm, L. B. Griffith, W. M. Griffith, O. S. Haines, J. E. Harner, A. L. Kistler, D. B. James, F. M. Lawrence, Z. T. Miller, O. H. Paxson, L. P. Posey, E. R. Snader, R. E. Tomlin, S. C. Webster.

A. B. Lichtenwalner, M. D., Philadelphia. "Serum Therapy."

Mary Branson, M. D., Philadelphia. "Some Peculiarities in the Temperature of Typhoid Fever."

C. H. Brown, M. D., Philadelphia. "A Clinical Eye Case."

I. B. Gilbert, M. D., Philadelphia. "Diphtheria."

W. M. Griffith, M. D., Philadelphia. "The Lingual Development."

O. S. Haines, M. D., Philadelphia. "A Discussion of the Treatment of Gastric Erosion and Gastric Ulceration."

W. J. Martin, M. D., Pittsburg. "The Way to Treat Typhoid Fever."

O. H. Paxson, M. D., Philadelphia. "What Would Hahnemann Do if He Were Here?"

E. R. Snader, M. D., Philadelphia. "A Discussion of the Prevention of Pulmonary Tuberculosis."

R. E. Tomlin, M. D., Philadelphia. "Cancer of the Alimentary Tract."

Evening Session, 8 to 10:30 o'clock.

SECTION OF OPHTHALMOLOGY, OTOLOGY AND LARYNGOLOGY.

H. F. Schantz, M. D., Chairman.

Associates.—Drs. W. W. Blair, E. W. Brickley, H. K. Hoy, H. I. Jessup, W. H. Lyle, F. W. Messerve, G. J. Palen, I. G. Shallcross, C. E. Spahr, William Spencer, G. W. Stewart, C. M. Thomas, Flora E. Wasserman, H. S. Weaver.

H. F. Schantz, M. D., Reading. "Digestive Ferments in the Treatment of Otorrhœa."

E. W. Brickley, M. D., York. "Pilocarpine in Optic Atrophy."

H. K. Hoy, M. D., Altoona. "Eczema of the External Auditory Canal."

G. J. Palen, M. D., Philadelphia. "Empyema of the Posterior Ethmoidal Cells and Sphenoidal Sinus: A Case."

William Spencer, M. D., Philadelphia. "The Advantage of Mule's Operation Over Enucleation."

Flora E. Wasserman, M. D., Philadelphia. "The Use of Hyperboloid Lenses on Conical Corneæ."

H. S. Weaver, M. D., Philadelphia. "The Association of Chronic Purulent Rhinitis With Diseases of the Accessory Sinuses."

After the adjournment of the Tuesday evening session of the Society there will be a reception to the ladies at the residence of Dr. J. A. Bullard, and a smoker for the male members and visitors at the West End Wheelmen's Club House.

WEDNESDAY, SEPTEMBER 26TH.

Morning Session, 9:30 to 1 o'clock.

SECTION OF OBSTETRICS.

E. W. Mercer, M. D., Chairman.

Associates.—Drs. Mary A. Cook, Isaac Crowther, Ella D. Goff, D. C. Kline, A. Korndoerfer, Jr., J. B. McClelland, G. W. Parker, Margaret H. Schantz, F. R. Schmucker, Emma T. Schreiner.

E. W. Mercer, M. D., Philadelphia. "Ectopic Gestation: A Report of Three Cases."

Mary A. Cook, M. D., Philadelphia. "Abortion."

Ella D. Goff, M. D., Allegheny. "Nausea and Vomiting of Pregnancy."

D. C. Kline, M. D., Reading. "Post-Partum Hæmorrhage."

Emma T. Schreiner, M. D., Philadelphia. "The Effect of Neurasthenia on Pregnancy and Lactation."

SECTION OF GYNAECOLOGY.

J. H. Thompson, M. D., Chairman.

Associates.—Drs. B. F. Betts, T. M. Bulick, W. H. A. Fitz, T. J. Gramm, C. H. Hofman, J. E. James, A. A. Lindabury, J. H. McClelland, J. L. Van Tine, Julia Gould Waylan.

J. H. Thompson, M. D., Pittsburg. "Extra-Peritoneal Hæmatocele."
W. H. A. Fitz, M. D., Philadelphia. "Prolapsus Uteri."
J. E. James, M. D., Philadelphia. "The After-Treatment of Abdominal Sections."
J. L. Van Tine, M. D., Philadelphia. "Chronic Endometritis."

Section of Pathology.

G. A. Van Lennep, M. D., Chairman.
Associates.—Drs. Clarence Bartlett, W. D. Bayley, W. D. Carter, T. S. Dunning, T. P. Gittens, W. C. Goodno, P. S. Hall, W. K. Ingersoll, E. H. Van Deusen.
Clarence Bartlett, M. D., Philadelphia. "Irregularity of the Pulse."
W. D. Carter, M. D., Philadelphia. "Vaccination."
E. H. Van Deusen, M. D., Philadelphia. "Hay Fever."

Afternoon Session, 3 to 6 o'clock.

Section of Materia Medica.

Augustus Korndoerfer, Sr., M. D., Chairman.
Associates.—Drs. A. P. Bowie, T. H. Carmichael, Edward Cranch, W. G. Dietz, P. S. Duff, J. M. Gerhart, W. J. Martin, R. P. Mercer, C. S. Middleton, Z. T. Miller, Charles Mohr, C. S. Schwenk, W. A. Seibert, G. W. Smith, R. T. White.
A. P. Bowie, M. D., Uniontown. "The Materia Medica Pura Hahnemann's Contribution to Medical Science."
Edward Cranch, M. D., Erie. "Drugs Used Homœopathically By the Old School."
W. G. Dietz, Hazleton. "The Remedies Homœopathic to Non-Traumatic Hæmorrhage."
W. J. Martin, M. D., Pittsburg. "Is Our Materia Medica Becoming One of the Lost Arts?"
R. P. Mercer, M. D., Chester. "A Proving of Phytolacca Decandra."
C. S. Middleton, M. D., Philadelphia. "Mercury in Syphilis."
Z. T. Miller, M. D., Pittsburg. "Conclusions After a Quarter of a Century."
Charles Mohr, M. D., Philadelphia. "The Relation of Pathology to Homœopathic Therapy."
C. S. Schwenk, M. D., Philadelphia. "Digitalis."
R. T. White, M. D., Pittsburg. "Convallaria."

On Wednesday evening the Homœopathic Medical Society of Northeastern Pennsylvania tenders a reception to the Society at the Wyoming Valley House.

THURSDAY, SEPTEMBER 27TH.

Morning Session, 9:30 to 1 o'clock.

SECTION OF PEDOLOGY.

Anna C. Clarke, M. D., Chairman.

Associates.—Drs. W. H. Bigler, J. D. Boileau, D. F. Brewster, F W. Burlingame, G. H. Clark, Sarah J. Coe, P. H. Ealer, M. J. Holben, T. M. Johnson, D. S. Kistler, J. L. Redman, W. W. Van Baun, J. D. Ward, Chandler Weaver, A. F. Ziegenfus.

Anna C. Clarke, M. D., Scranton. "Diabetes Mellitus: A Case."

W. H. Bigler, M. D., Philadelphia. "Dentition."

J. D. Boileau, M. D., Philadelphia. "Care of the Child's First Year."

D. F. Brewster, M. D., Scranton. "Antitoxine in Diphtheria and Membranous Croup."

F. W. Burlingame, M. D., McKeesport. "Rachitis."

M. J. Holben, M. D., Slatington. "A Case of Gangrene."

T. M. Johnston, M. D., Pittston. "Dysentery."

D. S. Kistler, M. D., Wilkesbarre. "Rachitis."

J. L. Redman, M. D., Philadelphia. "Intestinal Irrigation in Infantile Diarrhœa."

W. W. Van Baun, M. D., Philadelphia. "Adenitis in Childhood."

SECTION OF SURGERY.

J. W. Coolidge, M. D., Chairman.

Associates.—Drs. L. T. Ashcraft, Daniel J. Baker, G. M. Christine, E. R. Gregg, J. W. Hassler, Malcolm Macfarlan, D. P. Maddux, H. L. Northrop, R. C. Pitcairn, S. M. Rinehart, C. P. Seip, W. G. Steele, Walter Strong, L. W. Thompson, W. B Van Lennep, C. V. Vischer, L. H. Willard.

J. W. Coolidge, M. D., Scranton. "Cholelithiasis."

L. T. Ashcraft, M. D., Philadelphia. "Prostratitis and Its Treatment."

Daniel J. Baker, M. D., Philadelphia. "Some Remarks on a New Dusting Powder."

Bukk G. Carleton, M. D., New York. "Treatment of Gonorrhœa."
G. M. Christine, M. D., Philadelphia. "Appendicitis: Four Cases Illustrating Four Phases of the Disease."
J. W. Hassler, M. D., Philadelphia. "Anæsthesia."
H. L. Northrop, M. D., Philadelphia. "Tuberculosis of Bones and Joints."
L. W. Thompson, M. D., Philadelphia. "The Etiology of Cancer."
W. B. Van Lennep, M. D., Philadelphia. "Abdominal Drainage."

Afternoon Session, 2 to 5 o'clock.

Conclusion of Reports of Sections and Discussions.
Final Report of the Board of Censors.
Unfinished Business.
New Business.
Election of Officers.
Selection of Place for Next Meeting.
Appointment of Committees.
Announcement of Sections.
Adjournment.

REPORT OF THE COMMITTEE ON ORGANIZATION, REGISTRATION AND STATISTICS.

To the Homœopathic Medical Society of the State of Pennsylvania:

The Committee on Organization, Registration and Statistics herewith presents its annual report for publication.

Thirty-four local societies have returned reports and a detailed statement of the number of members in each, with their officers and terms and places of meeting.

The amount of work accomplished by the eleven hospitals and infirmaries and the six dispensaries from which we have received reports is given in detail and shows that these institutions are well deserving of our support.

We wish thro' this report to convey our thanks to all who have aided us by forwarding answers to our requests for data.

Respectfully submitted,

GEO. B. MORELAND, M. D.,
Chairman.

HOMŒOPATHIC MEDICAL SOCIETIES

Name.	President.	Secretary.
Lehigh Valley Homœo. Medical Society.	E. D. Doolittle, M. D., Easton.	D. W. Straub, M. D., Bethlehem.
Hom. Medical Society of Northeastern Penn.	Theo. M. Johnson, M. D., Pittston.	Anna C. Clarke, M. D., Scranton.
Hom. Medical Society of Chester, Delaware and Montgomery Co.	S. G. Godshall, M. D., Edge Hill.	Isaac Crowther, M. D., Chester.
Hom. Medical Society of Philadelphia County.	James H. Closson, M. D., Philadelphia.	H. P. Leopold, M. D., Philadelphia.
Hom. Medical Society of Allegheny County.	G. B. Moreland, M. D., Pittsburg.	John C. Calhoun, M. D., Allegheny.
Hom. Med. Society of the 23d Ward, Phila.	R. E. Tomlin, M. D., Phila.	J. D. Boileau, M. D., Philadelphia.
Hom. Med. Soc. of Central Pennsylvania.	E. H. Morrow, M. D., Altoona.	M. A. Wesner, M. D., Johnstown.
Hom. Medical Society of Schuylkill County.	G. W. Dietz, M. D., Hazleton.	L. A. Snyder, M. D., Ashland.
Alumni Association of Hahn. Med. College.	Chas. A. Gale, M. D., Rutland, Vt.	W. D. Carter, M. D., Philadelphia.
Hom. Medical Society of Beaver County.	Evelyn S. Pettit, M. D., New Brighton.	Wm. Raymer, M. D., Beaver Falls.
Germantown Hom. Med. Soc. of Philadelphia.	L. P. Posey, M. D., Philadelphia.	J. H. Closson, M. D., Germantown.
Hahnemann Club of Philadelphia.	John E. James, M. D., Philadelphia.	T. S. Dunning, M. D., Philadelphia.
Oxford Medical Club of Philadelphia.	E. M. Gramm, M. D., Philadelphia.	G. W. Smith, M. D., Philadelphia.
Hahn. Association of Western Penna.	Mr. D. G. Stewart, Pittsburg.	J. H. McClelland, M. D., Pittsburg.
Women's Hom. Medical Club of Phila.	Mary Branson, M. D., Philadelphia.	Lydia W. Stokes, M. D., Philadelphia.
Bœnninghausen Med. Club of Phila.		Geo. W. Smith, M. D., Philadelphia.
Hom. Practitioners' Association of Reading.	J. E. Harner, M. D., Reading.	F. W. Seidel, M. D., Reading.
A. R. Thomas Club of Philadelphia.	W. W. Speakman, M. D., Philadelphia.	A. A. Norris, M. D., Philadelphia.
Saturday Night Club of Microscopists.	J. C. Guernsey, M. D., Philadelphia.	Nathan Smilie, M D, Philadelphia.
Philadelphia Clinical Society.	C. M. Thomas, M. D., Philadelphia.	W. H. Bigler, M. D., Philadelphia.
Phila. Medical Club.	Wm. H. Keim, M. D., Philadelphia.	E. H. Van Deusen, M. D., Philadelphia.
East End Doctors' Club of Pittsburg.	J. H. McClelland, M. D., Pittsburg	C. I. Wendt, M. D., Pittsburg.
Hom. Pharmaceutical Association of Penna.	F. J. Slough, M D., Allentown.	E. P. Anshutz, M. D., Philadelphia.
Hom. Med. Society of Montgomery County.	E. B. Rossiter, M. D., Pottstown.	H. M. Bunting, M. D., Norristown.
Hom. Medical Society of Delaware County.	R. P. Mercer, M. D., Chester.	G. C. Webster, M. D., Chester.
Hom. Medical Society of Chester County.	S. A. Mullen, M. D., West Chester.	L. Hoopes, M. D., West Chester.
Hom. Medical Society of Luzerne County.	Edward C. Dreher, M. D., Wilkesbarre.	J. A. Brooke, M. D., Wilkesbarre.
Women's Hom. Medical Association of Pittsburg.	M. J. Chapman, M. D., Pittsburg.	Anna Johnston, M. D., Pittsburg.

OF THE STATE OF PENNSYLVANIA.

Organized.	Incorporated.	When Meetings are held.	Where Meetings are held.	No. Members.	No. Admitted Last Year.	No. Deceased Last Year.	Annual Dues.
1881	Not.	Bi-Monthly.	No stated place.	25	3	0	$1.00
1887	"	June, October.	Wilkesbarre. Scranton.	32	2	0	2.00
1858	"	Annually.	Phila.	64	9	2	1.00
1864	"	Monthly.	Pittsburg.	74	2	1	2.00
1881	"	"	Phila.	26	3	0	1.50
1883	"	Quarterly.	No stated place.	22	3	0	. .
1851	"	Annually.	Phila.	1375	56	12	. .
1881	"	Monthly.	No stated place.	13	0	0	1.00
1879	"	"	No stated place.	182	20	1	1.00
1872	"	"	No stated place.	10	0	1	. .
1885	"	"	No stated place.	15	0	0	2.00
1896	"	Annually.	No stated place.	200	0	0	2.00
1883	"	Monthly.	No stated place.	15	1	0	. .
1896	"	"	Reading.	18	2	0	1.00
1888	"	"	Phila.	17	0	0	.
1894	"	"	Phila.	51	5	0	1.00
1880	"	Bi-Monthly.	Phila.	10	0	0	. .
1880	"	Monthly.	Phila.	14	0	1	. .
1895	"	"	Pittsburg.	18	2	0	1.00
1881	1881	At call of President.	Phila.	13	0	0	. .
1898	"	Bi-Monthly.	Chester.	22	3	1	1.00
1898	"	"	No stated place.	11	0	1	1.00
1899	"	Monthly.	No stated place.	14	0	0	. .
1900	Not.	Monthly.	No stated place.	5	5	0	. .

HOMŒOPATHIC MEDICAL SOCIETIES

Name.	President.	Secretary.
Von Grauvogl Medical Club.	J. H. Closson, M. D., Germantown.	Gilbert J. Palen, M. D., Germantown.
Organon Medical Club.	R. P. Mercer, M. D., Chester.	D. P. Maddux, M. D., Chester.
Lackawanna Hom. Med. Society.	F. D. Brewster, M. D., Scranton.	J. L. Peck, M. D., Scranton.
Wm. B. Van Lennep Clinical Club.	C. J. V. Fries, M. D., Philadelphia.	J. W. Hassler, M. D., Philadelphia.
Goodno Hom. Medical Society.	D. W. Horner, M. D.	E. T. Prizer, M. D., Lancaster.

OF THE STATE OF PENNSYLVANIA.

Organized.	Incorporated.	When Meetings are held.	Where Meetings are held.	No. Members.	No. Admitted Last Year.	No. Deceased Last Year.	Annual Dues.
1899	"	"	Phila.	12	12	0	. .
1887	"	"	Chester.	15	1	0	. .
1900	"	"	Scranton.				
1894	"	"	Phila.	15	1	1	$2.00
	"	Quarterly.	No stated place.	12	0	0	. .

HOMŒOPATHIC DISPENSARIES

Name.	Location.	Executive Officer or Secretary.
Homœopathic Free Dispensary.	Pittsburg.	W. D. Slack, Supt.
Hahnemann Hospital Dispensary.	Philadelphia.	Wm. G. Foulke, Secretary.
Children's Homœopathic Dispensary.	Philadelphia.	N. F. Lane, M. D.
St. Luke's Homæopathic Dispensary.	Philadelphia.	John M. Zook.
Dispensary of the Medical, Surgical and Maternity Hospital of the Women's Homœopathic Association of Penna.	Philadelphia.	Mrs. R. T. Mason, School House Lane, Phila.
Hahnemann Hospital Dispensary.	Scranton.	Mrs. M. H. Holgate.
Reading Homœopathic Dispensary.	Reading.	H. F. Schantz, M. D., Secretary.

HOMŒOPATHIC HOSPITALS AND INFIRMARIES

Name.	Location.	Executive Officer or Secretary.	Incorporated.	Opened to Patients.	No. of Beds
Medical, Surgical and Maternity Hospitals of the Women's Homœopathic Association of Penna.	Philadelphia.	Mrs R. T. Mason, School House Lane, Philada.	1882	1884	80
Children's Homœopathic Hospital of Philadelphia.	Philadelphia.	N. N. Lane, M. D.	1877	1877	65
Homœopathic Medical and Surgical Hospital of Pittsburg.	Pittsburg.	W. D. Slack, Supt.	1866	1866	160
Hahnemann Medical College Hospital of Philadelphia.	Philadelphia.	Wm. G. Foulke.	1869	1871	200
Hahnemann Hospital of Scranton.	Scranton.	Mrs. H. M. Boies.	1898	1898	30
St. Luke's Homœopathic Hospital of Philadelphia.	Philadelphia.	A. M. Barnes, M. D.	1896	1896	15
Benedictine Infirmary.	Erie.	Benedictine Sisters.	. .	1851	10
Beaver Valley General Hospital (staff equally divided between Allopaths and Homœopaths.)	New Brighton	Jas. F. Merriman.	1895	1895	28
Reading Homœopathic Hospital.	Reading.	L. A. Schollenberger, M. D.	1890	1891	22
Women's Southern Homœopathic Hospital of Philadelphia.	Philadelphia.	Annie M. Miller.	1896	1896	30
J. Lewis Crozer Home for Incurables.	Upland, Pa.	Miss Mary Ulrich.	1899	1900	40

OF THE STATE OF PENNSYLVANIA.

Incorporated.	Opened to Patients.	No. of New Patients Last Year.	No. of Patients Treated Last Year.	No. of Prescriptions Last Year.	No. of Visits to Out-Door Patients.
1866	1866	11,482	21,397	16,742	None.
1848	1848	30,441	34,878	117,502	None.
1877	1877	. . . . .	. . . . .	. . . . .	. . . . .
1896	1896	. . . . .	. . . . .	. . . . .	. . . . .
1882	1884	. . . . .	7,113	15,648	4,913
1898	1898	101	101	596	. . . . .
1890	1888	. . . . .	1,762	6,320	. . . . .

OF THE STATE OF PENNSYLVANIA.

No. of Patients Last Year.	Cured.	Relieved.	Not Relieved.	Died.	Estimated Value of Hospital and Grounds.	Amount of Productive Property,	Sources of Income.
658	533	31	12	31	$250,000.00	$70,000.00	Donations. State aid.
. . .	. . .	. . .	. . .	. . .	. . . . .	. . . . .	. . . . .
1975	. . .	. . .	. . .	. . .	271,073.00	. . . . .	Donations. State aid.
1921	. . .	. . .	. . .	. . .	722,907.00	230,592.00	Donations. State aid.
214	119	69	9	4	Leased.	. . . . .	Donations. State aid.
. . .	. . .	. . .	. . .	. . .	10,000.00	. . . . .	. . . . .
260	230	27	2	1	. . . . .	. . . . .	. . . . .
202	132	17	24	25	. . . . .	. . . . .	Donations. State aid.
181	133	27	3	8	35,000.00	. . . . .	Donations. State aid.
. . .	. . .	. . .	. . .	. . .	. . . . .	. . . . .	. . . . .
. . .	. . .	. . .	. . .	. . .	150,000.00	35 acres.	Endowment.

HOMŒOPATHIC MEDICAL JOURNALS OF THE STATE OF PENNSYLVANIA.

Name.	Editors and Publishers, and Place of Publication.	When Established.	Pages in Each Number.	Subscription Price.	How Often Published.	Form.
Hahnemannian Monthly.	W. W. Van Baun, M. D., 1402 Spruce St., Phila.	1865	96	$3.00	Monthly.	Octavo.
Homœopathic Envoy.	E. P. Anshutz, P. O. Box 921, Phila.	1890	8	.25	Monthly.	Quarto.
Homœopathic Recorder.	E. P. Anshutz, P. O. Box 921, Phila. Boericke & Tafel, 1011 Arch St., Phila.	1886	48	1.00	Monthly.	Octavo.
The Homœopathic Physician.	Walter M. James, M. D., 1231 Locust St., Phila.	1881	48	2.50	Monthly.	Octavo.
Hospital News.	Verner S. Gaggin, M. D., Hom. Hosp. Pittsburg.	1896	8	.10	Monthly.	Quarto.
Hahnemannian Institute.	Students Hahnemann.	1893	16	.50	Monthly.	Quarto.

REPORT OF THE HAHNEMANN MONUMENT COMMITTEE.

Dr. W. J. Martin, Chairman of the Hahnemann Monument Committee, reported that, of the $13,100 subscribed by Pennsylvania, $11,395 had been paid, leaving an unpaid balance of $1,705; $1,000 of which is sure to be paid and the rest will probably never be paid. He asked that the committee be discharged. On motion, the report was received and ordered printed with the list of names of subscribers appended. A vote of thanks was extended by the Society to Dr. Martin and his associates on the committee, for the excellent manner in which they had carried on the work.

SUBSCRIBERS TO HAHNEMANN MONUMENT FUND.

Adams, Mrs. S. Jarvis, Pittsburg,	50.00	50.00
Addenbrook, Thos., Esq., Braddock, Pa.,	3.00	3.00
Albright, Adalaide L., M. D., Philadelphia,	50.00	50.00
Alden & Harlow, Messrs., Pittsburg,	20.00	20.00
Allegheny Co. Homœopathic Medical Society, Pa.,	100.00	100.00
Allen, Joshua, M. D., Philadelphia,	10.00	10.00
Allen, Richard C., M. D., Philadelphia,	5.00	5.00
Allen, Richard C., M. D., Philadelphia,	10.00	
Baier, Geo. T., M. D., Norwood, Pa.,	5.00	5.00
Bainbridge, Benj. F., M. D., Philadelphia,	1.50	1.50
Baker, Albra W., M. D., Emporium, Pa.,	5.00	5.00
Bartlett, Clarence, M. D., Philadelphia, Pa.,	50.00	25.00
Beaver County Homœopathic Medical Society, Pennsylvania,	11.00	11.00
Berens, Joseph, M. D., Philadelphia,	20.00	20.00
Betts, B. Frank, M. D., Philadelphia,	50.00	50.00
Biddle, Jesse T., M. D., Monongahela, Pa.,	5.00	5.00
Bier, Peter A., M. D., Pittsburg,	10.00	10.00
Bigelow, Wm. S., M. D., Phillipsburg, Pa.,	2.00	2.00
Bigler, William H., M. D., Philadelphia,	5.00	5.00
Bingaman, C. F., M. D., Pittsburg,	100.00	100.00
Blair, Wm. W., M. D., Pittsburg,	50.00	10.00
Boericke & Tafel, Philadelphia,	150.00	150.00
Bonham, Elizabeth Nimick, Pittsburg, Pa. (Dime Bank),	5.00	5.00
Bowie, Alonzo P., M. D., Uniontown, Pa.,	50.00	25.00
Bowie, Eleazer, Uniontown,	5.00	5.00
Bowie, Miss Elizabeth W., Uniontown,	5.00	5.00
Bowie, Mrs. Mary Robinson, Uniontown,	10.00	10.00
Boyd, Geo. S., M. D., Beaver Falls, Pa.,	3.00	3.00
Boyd, J. S., M. D., New Brighton, Pa.,	5.00	5.00
Bradford, Geo. M., M. D., Mt. Morris,	5.00	5.00
Bradford, Thos. L., M. D., Philadelphia,	50.00	50.00
Branson, Mary, M. D., Philadelphia, Pa.,	80.00	80.00
Brewer, Mary, M. D., Philadelphia,	5.00	5.00
Brierly, F. F., Esq., Beaver Falls, Pa.,	2.00	2.00
Briggs, Elmer E., M. D., Pittsburg,	10.00	
Bronn, Wm. H., M. D., Butler,	1.00	1.00
Brown, Mrs. Ella Martin, Pittsburg, Pa.,	50.00	50.00
Brown, Henry Graham, Esq., Pittsburg, Pa.,	25.00	25.00

Brown, Samuel G. A., M. D., Shippensburg, Pa.,	5.00	5.00
Brown, William K., M. D., Philadelphia, Pa.,	50.00	50.00
Brown, W. H., Esq., Pittsburg,	25.00	25.00
Bryson, H. Ballou, M. D., Pittsburg, Pa.,	10.00	10.00
Buchman, Francis, M. D., Philadelphia,	25.00	25.00
Bullard, J. Arthur, M. D., Wilkesbarre, Pa.,	5.00	5.00
Burgher, John C., M. D., Pittsburg,	25.00	25.00
Burlingame, Frank W., M. D., McKeesport, Pa.,	5.00	5.00
Calhoun, John C., M. D., Pittsburg, Pa.,	25.00	25.00
Cappeau, Mrs. J. O. P., Pittsburg, Pa.,	5.00	5.00
Carmichael, Thomas H., M. D., Philadelphia,	25.00	25.00
Cash, Beaver Falls, Pa.,	.50	.50
Central Pennsylvania Homœopathic Medical Society,	25.00	25.00
Chase, Theo. L., M. D., Philadelphia, Pa.,	2.00	2.00
Challinor, David, Esq., Pittsburg,	100.00	100.00
Champlin, Henry W., M. D., Bloomsburg, Pa.,	10.00	10.00
Chantler, Israel B., M. D., Sewickley, Pa.,	20.00	
Chapman, Millie J., M. D., Pittsburg,	50.00	50.00
Christine, G. M., M. D., Philadelphia,	5.00	5.00
Clark, George H., M. D., Philadelphia,	30.00	30.00
Clarke, Chas. J., Esq., Pittsburg,	200.00	200.00
Cline, Mrs. Elizabeth, Brownsville, Pa.,	5.00	5.00
Closson, James H., M. D., Philadelphia,	15.00	15.00
Closson, Mrs. Jas. H., Philadelphia,	5.00	5.00
Closson, Jas. Harwood, 3d, Philadelphia,	5.00	5.00
Closson, Miss Josephine Banes, Philadelphia,	5.00	5.00
Closson, Miss Mary Bancroft, Philadelphia,	5.00	5.00
Coe, Sarah J., M. D., Wilkesbarre, Pa.,	20.00	20.00
Coffin, Lemuel, Philadelphia,	250.00	
Cook, W. S., D. D. S., Beaver Falls, Pa.,	2.00	2.00
Cooke, Mary S., M. D., Philadelphia,	5.00	5.00
Cooper, John F., M. D., Pittsburg,	105.00	105.00
Cooper, John, M. D., Allegheny, Pa.,	5.00	5.00
Corey, Carl and Foster, Pittsburg, Pa. (Dime Bank),	5.00	5.00
Corey, W. E., Esq., Munhall, Pa.,	25.00	25.00
Corcoran, Mrs. W. D., Pittsburg, Pa.,	50.00	50.00
Cowley, William, M. D., Pittsburg, Pa.,	5.00	
Cranch, Edward, M. D., Erie, Pa.,	10.00	10.00
Dake, Benjamin F., M. D., Pittsburg,	25.00	25.00
Danforth, Mrs. J. H.,	1.00	1.00
Davies, John M., M. D., Warren, Pa.,	5.00	5.00
Dean, Edward W., M. D., Braddock, Pa.,	25.00	25.00
Dean, Misses H. M. and J., Philadelphia,	100.00	100.00
Dehoff, John W., M. D., York,	10.00	10.00
Delaware County (Pa.) Homœopathic Medical Society,	10.00	10.00
Del., Chest. & Mont. Co.'s Society, Pennsylvania,	75.00	75.00
Detlefhs, M. E., Esq., Sharpsburg,	5.00	5.00
Detwiller, John J., M. D., Easton, Pa.,	30.00	30.00
Dinsmore, Marion H., Sharpsburg, Pa. (Dime Bank),	100.00	100.00
Dinsmore, S. W. S., M. D., Sharpsburg, Pa.,	50.00	50.00
Douds, John M., M. D., Beaver Falls, Pa.,	2.00	2.00
Drake, J. C. Merle, M. D., Erie, Pa.,	10.00	10.00
Doyle, H. Harrison, M. D., Pittsburg, Pa.,	5.00	
Douredoure, B. L., Esq., Philadelphia,	10.00	10.00
Dudley, Pemberton, M. D., Philadelphia,	50.00	50.00
Duff, P. S., M. D., Great Belt, Pa.,	4.00	4.00

Earhart, Wm. J., M. D., Philadelphia, Pa.,	200.00	200.00
East End Doctors' Club, Pittsburg,	20.00	20.00
Edmundson, W. F., M. D., Pittsburg,	100.00	25.00
Eklins, George W., Esq., Philadelphia, Pa.,	100.00	100.00
Elkins, Wm. L., Esq., Philadelphia, Pa.,	100.00	100.00
Elkins, Wm. L., Jr., Esq., Philadelphia, Pa.,	100.00	100.00
Evans, H. J., M. D., Altoona, Pa.,	25.00	25.00
Fanning, E. Burrell, M. D., Philadelphia, Pa.,	5.00	5.00
Ferson, John L., M. D., Pittsburg,	15.00	15.00
Findley, J. B., Esq., Pittsburg, Pa.,	100.00	100.00
Fisher, George S., M. D., Lebanon, Pa.,	1.00	1.00
Fisher, John, M. D., Philadelphia,	5.00	5.00
Fleming, Richard K., M. D., Pittsburg, Pa.,	10.00	10.00
Flint, John F., M. D., Erie, Pa.,	8.00	8.00
Friend, A., Pittsburg,	10.00	10.00
Friend, James K., Esq., Pittsburg, Pa.,	100.00	100.00
Fulton, Henry W., M. D., Pittsburg, Pa.,	100.00	100.00
Fundis, William Roy, Pittsburg, Pa. (Dime Bank),	5.00	5.00
Gaggin, Verner S., M. D., Pittsburg, Pa.,	5.00	5.00
Galster, Herman C., M. D., Erie, Pa.,	8.00	8.00
Gangloff, Chas. L., M. D., Pittsburg, Pa.,	5.00	5.00
Gangloff, Charles L., M. D., Pittsburg, Pa.,	10.00	10.00
Garner, Jarvis A., Pittsburg, Pa. (Dime Bank),	5.00	5.00
Garner, Miss Virginia, Pittsburg, Pa. (Dime Bank),	5.00	5.00
Gaun, Geo. W., M. D., Dubois, Pa.,	5.00	5.00
Gerberich, George, Esq., Lebanon, Pa.,	1.00	1.00
Gerberich, Morris B., M. D., Lebanon, Pa.,	5.00	5.00
Gerhart, Joseph M., M. D., Philadelphia,	5.00	5.00
Gifford, Edward F., M. D., Erie, Pa.,	8.00	8.00
Godshall, Samuel G., M. D., Edge Hill, Pa.,	5.00	5.00
Goff, Ella D., M. D., Allegheny, Pa.,	50.00	50.00
Goodno, Wm. C., M. D., Philadelphia, Pa.,	100.00	100.00
Gregg, Edward Rollin, M. D., Pittsburg,	50.00	
Gregg, Rollin R., M. D. (in memory of), Pittsburg	50.00	
Griffith, John B., M. D., Lewistown,	5.00	5.00
Grote, H. C., Esq., Pittsburg, Pa.,	10.00	10.00
Grote, Herman L., Esq., Pittsburg, Pa.,	25.00	25.00
Guernsey, Jos. C., M. D., Philadelphia,	50.00	50.00
Guffey, Col. J. M., Pittsburg	100.00	100.00
Guffey, Miss Elsie, Pittsburg, Pa. (Dime Bank),	5.00	5.00
Guffey, Miss Mary, Pittsburg, Pa. (Dime Bank),	5.00	5.00
Gumpert, Benj. B., M. D., Philadelphia,	5.00	5.00
Haas, Clifford, Pittsburg, Pa. (Dime Bank),	5.00	5.00
Hahnemann Hospital, Scranton,	100.00	100.00
Hahnemann Medical College of Philadelphia,	100.00	100.00
Haman, Wm. A., M. D., Reading,	5.00	5.00
Hamilton, Samuel, Esq., Pittsburg,	25.00	25.00
Hammett, Fred. W., M. D., Philadelphia,	5.00	5.00
Hancock, Byron, Philadelphia,	10.00	10.00
Hancock, Mrs. Joseph, Philadelphia,	10.00	10.00
Hancock, Jos., M. D., Philadelphia, Pa.,	100.00	100.00
Hancock, Judson, Philadelphia,	10.00	10.00
Hassler, J. Wyllis, M. D., Philadelphia,	1.00	1.00
Hassler, M. Margaret, M. D., Allentown, Pa.,	1.00	1.00
Hassler, Wm. A., M. D., Allentown, Pa.,	5.00	5.00
Hays, Louis P., Esq., Pittsburg, Pa.,	100.00	100.00

Hays, Miss Virginia Claire, Pittsburg, Pa.,	240.00	240.00
Heimbach, A. E., M. D., Renova, Pa.,	5.00	5.00
Heinz, H. J., Esq., Pittsburg, Pa.,	250.00	250.00
Heinz, Miss Irene, Pittsburg, Pa.,	10.00	10.00
Hering, Mrs. Constantine, Philadelphia,	25.00	25.00
Hoffstot, Frank N., Esq., Pittsburg, Pa.,	100.00	100.00
Hofman, Charles H., M. D., Pittsburg,	25.00	25.00
Homœopathic Hospital and Dispensary, Reading, Pa.,	25.00	25.00
Homœopathic Hospital Interns, Pittsburg,	20.00	20.00
Homœopathic Medical Society of Germantown, Pa.,	125.00	125.00
Homœopathic Medical Society of Northern Pennsylvania,	50.00	50.00
Homœopathic Medical Society of 23d Ward, Philadelphia,	116.00	116.00
Horner, Mrs. A. W., Allegheny, Pa.,	10.00	10.00
Horner, James Richey, Jr., Allegheny, Pa.,	10.00	10.00
Horner, William Wattles, Allegheny, Pa.,	10.00	10.00
Howard, Miss Rebecca, Pittsburg, Pa.,	5.00	5.00
Hoy, Harvey K., M. D., Altoona, Pa.,	5.00	5.00
Humes, James R., M. D., Hollidaysburg, Pa.,	10.00	10.00
Irwin, Thos. A., M. D., Franklin,	5.00	5.00
James, Bushrod W., M. D., Philadelphia,	200.00	200.00
James, John E., M. D., Philadelphia, Pa.,	30.00	30.00
Jamison, R. M., M. D., Greensburg, Pa.,	5.00	5.00
Jennings, E. H., Esq., Pittsburg,	100.00	100.00
Jones, Hon. B. F., Pittsburg, Pa.,	500.00	500.00
Jones, N. D., Esq., Pittsburg,	50.00	50.00
Kase, Edmund H., M. D., Philadelphia,	5.00	5.00
Keim, Wm. H., M. D., Philadelphia,	10.00	10.00
Kerr, John D., Esq., Homestead,	1.00	1.00
King, Mrs. William D., Pittsburg,	25.00	
King, William D., M. D., Pittsburg,	25.00	
Kinkead, Mrs. Catherine, Turtle Creek,	3.00	3.00
Kistler, Horace E., M. D., Johnstown, Pa.,	10.00	10.00
Korndoerfer, August, M. D., Philadelphia,	100.00	100.00
Krusen, Edward A., M. D., Collegeville,	10.00	10.00
Laird, William M., Pittsburg,	10.00	10.00
Lehigh Valley Homœopathic Medical Society, Pennsylvania,	65.00	65.00
Lentz, Levi R., M. D., Fleetwood, Pa.,	5.00	5.00
Lichtenwalner, Abbot B., M. D., Philadelphia,	8.20	8.20
Lippincott, Mrs. Anna Janney, Philadelphia,	50.00	50.00
Loos, Julia C., M. D., Harrisburg, Pa.,	3.00	3.00
MacFarlan, Malcolm, M. D., Philadelphia,	25.00	25.00
Macfarlan, Duncan, M. D., Philadelphia,	20.00	20.00
Mackenzie, George W., M. D., Philadelphia, Pa.,	5.00	5.00
Maddux, Daniel P., M. D., Chester, Pa.,	5.00	5.00
Magee, Mrs. C. H., Philadelphia,	100.00	100.00
Magee, Wm. S., Esq., Philadelphia,	100.00	100.00
Magee, Mrs. Wm. S., Philadelphia,	100.00	100.00
Mansfield, Job R., M. D., Philadelphia,	5.00	5.00
Marshall, Robert S., M. D., Pittsburg, Pa.,	50.00	50.00
Marshall, Anna M., M. D., Philadelphia,	5.00	5.00
Martin, Constantine H., M. D., Allentown, Pa.,	15.00	15.00
Martin, Miss Ella S., Pittsburg,	10.00	10.00
Martin, Mrs. Nancy, Pittsburg, Pa.,	50.00	50.00
Martin, W. J., M. D., Pittsburg,	200.00	200.00

Martin, Mrs. W. J., Pittsburg,	10.00	10.00
Maurer, Joseph M., M. D., Washington, Pa.,	20.00	20.00
McAllister, J. W., Esq., Philadelphia,	25.00	25.00
McCauley, John C., M. D., Rochester,	10.00	10.00
McClelland, J. H., M. D., Pittsburg, Pa.,	505.00	505.00
McClelland, John B., M. D., Pittsburg,	105.00	105.00
McClelland, Miss Mary W. P., Pittsburg, Pa.,	10.00	10.00
McClelland, Miss Rachel P., Pittsburg, Pa. (Dime Bank),	15.00	15.00
McClelland, Mrs. Rachel P., Pittsburg,	60.00	60.00
McClelland, Miss Sarah C., Pittsburg, Pa. (Dime Bank),	15.00	15.00
McClelland, Robert W., M. D., Pittsburg,	105.00	105.00
McClure, Eliza Lang, M. D., Philadelphia,	30.00	30.00
McCormick, J. C., Esq., Edgewood Park,	2.00	2.00
McCutcheon, Jas. H., Esq., Pittsburg, Pa.,	25.00	25.00
McCutcheon, Mrs. Mary, Pittsburg, Pa.,	10.00	10.00
McCrady, J. H., Esq., Edgewood Park,	1.00	1.00
McGarrah, Olin K., M. D., Altoona, Pa.,	10.00	10.00
McGeary, Geo. H., M. D., Braddock,	5.00	5.00
McIlroy, W. P., M. D., Allegheny, Pa.,	5.00	5.00
Middleton, Caleb S., M. D., Philadelphia,	50.00	50.00
Miller, Zachary T., M. D., Pittsburg, Pa.,	55.00	55.00
Mitchell, John Nicholas, M. D., Philadelphia, Pa.,	25.00	25.00
Mohr, Chas., M. D., Philadelphia,	25.00	25.00
Mohr, Mrs. Chas., Philadelphia,	5.00	5.00
Mohr, Miss Harriet H., Philadelphia,	5.00	5.00
Mohr, Miss Jean H., Philadelphia,	5.00	5.00
Moon, Seymour B., M. D., Beaver Falls, Pa.,	15.00	15.00
Moorhead, Mrs. Mary H., Pittsburg, Pa.,	25.00	25.00
Morrow, Emory H., M. D., Altoona, Pa.,	10.00	10.00
Moreland, George B., M. D., Pittsburg, Pa.,	5.00	5.00
Mueller, Gustave A., M. D., Pittsburg, Pa.,	100.00	100.00
Murdock, Robert, M. D., Wilkesbarre, Pa.,	5.00	5.00
Myers, Charles E., M. D., Philadelphia,	5.00	5.00
Negley, Miss Alice, Pittsburg, Pa.,	5.00	5.00
Negley, Miss Georgina, Pittsburg, Pa.,	5.00	5.00
Neidhard, Charles, M. D., Philadelphia,	25.00	25.00
Nicholson, H. S., Esq., Pittsburg, Pa.,	5.00	5.00
Nimick, W. Howard, Esq., Pittsburg,	25.00	25.00
Norton, Claude R., M. D., Philadelphia,	5.00	5.00
O'Donnell, J. C., M. D., Braddock,	5.00	5.00
Oliver, Mrs. Henry W., Pittsburg, Pa.,	100.00	100.00
Organon Medical Club, Chester, Pa.,	10.00	10.00
Painter, Chas. A., Esq., Pittsburg, Pa.,	50.00	50.00
Palen, Gilbert J., M. D., Germantown,	5.00	5.00
Parsons, Edgar C., M. D., Meadville, Pa.,	10.00	10.00
Patterson, John M., Esq., Pittsburg, Pa.,	50.00	
Peach, William, M. D., Allegheny, Pa.,	5.00	5.00
Pearre, Walter, M. D., Waynesboro, Pa.,	5.00	5.00
Peet, E. Leland, M. D., Peckville, Pa.,	5.00	5.00
Perkins, Chas. W., M. D., Chester,	10.00	10.00
Perrine, J. K., M. D., Pittsburg,	50.00	
Perrot, J. D., Esq., Beaver Falls, Pa.,	2.00	2.00
Peterson, Pierson B., M. D., Honesdale,	5.00	5.00
Pettengill, Eliza, M. D., Philadelphia,	5.00	5.00
Phillips, Hibbard S., M. D., Pittsburg, Pa.,	5.00	
Phillips, Joseph R., M. D., Erie Pa.,	20.00	20.00

Piper, Robert L., M. D., Tyrone, Pa.,	5.00	5.00
Pitcairn, Hugh M., M. D., Harrisburg, Pa.,	25.00	25.00
Pitcairn, Mrs. Robert, Pittsburg, Pa.,	100.00	100.00
Pittsburg Homœopathic Physicians (Additional),	16.00	16.00
Porter, Joshua V., M. D., Pittsburg,	10.00	
Posey, Louis Plummer, M. D., Philadelphia,	5.00	5.00
Powell, Franklin, M. D., Chester, Pa.,	100.00	100.00
Powell, William C., M. D., Bryn Mawr, Pa.,	25.00	25.00
Pratt, Trimble, M. D., Media, Pa.,	5.00	5.00
Preston, Mahlon, M. D., Norristown, Pa.,	10.00	10.00
Quinby, Edgar C., M. D., Titusville, Pa.,	2.00	2.00
Randall, Edward G., M. D., Philadelphia,	1.00	1.00
Rankin, John S., M. D., Pittsburg,	50.00	50.00
Rankin, Mrs. Louisa G., Pittsburg,	50.00	50.00
Raymer, Wm., M. D., Beaver Falls, Pa.,	2.00	2.00
Reading, J. Herbert, M. D., Philadelphia,	10.00	10.00
Reeves, Joseph M., M. D., Philadelphia, Pa.,	25.00	25.00
Reinhold, Hannah C., M. D., Williamsport, Pa.,	5.00	5.00
Reinhart, Clarence C., M. D., Pittsburg, Pa.,	50.00	50.00
Rousseau, Louis G., M. D., Pittsburg,	10.00	10.00
Rowland, Joseph, Esq., Philadelphia, Pa.,	1.00	1.00
Sandel, John H., M. D., Plymouth,	10.00	10.00
Sartain, Harriet J., M. D., Philadelphia,	5.00	5.00
Shoemaker, Daniel W., M. D., Philadelphia,	10.00	10.00
Schoen, W. H., Esq., Pittsburg, Pa.,	100.00	100.00
Schoonmaker, J. M., Jr., Pittsburg, Pa., (Dime Bank),	5.00	5.00
Schreiner, Emma T., M. D., Germantown, Pa.,	10.00	10.00
Schuylkill County Homœopathic Medical Society, Pennsylvania,	125.00	125.00
Schwenk, Clayton S., M. D., Philadelphia,	.70	.70
Seabury, W. W., M. D., DuBois, Pa.,	5.00	5.00
Seip, Christian P., M. D., Pittsburg, Pa.,	50.00	50.00
Shallcross, Isaac G., M. D., Philadelphia,	5.00	
Shannon, Orlando R., M. D. Allegheny, Pa.,	5.00	
Shannon, William T., Pittsburg,	25.00	25.00
Shute, A. Clement, M. D., Connellsville, Pa.,	5.00	5.00
Simpson, Edna and Kenneth, Pittsburg, Pa., (Dime Bank),	5.00	5.00
Smedley, Chas. D., M. D., Wayne, Pa.,	5.00	5.00
Smedley, Isaac G., M. D., Philadelphia,	25.00	25.00
Smith, Mary E., M. D., Allegheny, Pa.,	5.00	5.00
Smith, Col. N. M., Pittsburg, Pa.,	5.00	5.00
Smith, Mrs. N. M., Pittsburg, Pa.,	5.00	5.00
Smith, T. Hart, M. D., Philadelphia,	50.00	50.00
Somerville, Wm. H., M. D., Philadelphia,	5.00	5.00
Sperling, John D., M. D., Wilkesbarre, Pa.,	100.00	100.00
Starr, Pearl, M. D., Bellevue, Pa.,	5.00	5.00
Stephenson, Mrs. Elizabeth Paterson, Pittsburg, Pa.,	10.00	10.00
Stephenson, F. L., Esq., Pittsburg, Pa.,	50.00	50.00
Stephens, Drs. Wm. R. and Thos. W., Wilkinburg, Pa.,	10.00	10.00
Stitzel, J. Wakefield, M. D., Hollidaysburg, Pa.,	5.00	5.00
Steudel, Robert, M. D., Phoenixville, Pa.,	5.00	5.00
Stewart, D. Glenn, Jr., Pittsburg, Pa., (Dime Bank),	5.00	5.00
Stewart, Wm. Alvah, M. D., Pittsburg, Pa.,	50.00	50.00
Thatcher, Jesse W., M. D., Philadelphia, Pa.,	5.00	5.00
Thaw, Alice C., Pittsburg, Pa. (Dime Bank),	5.00	5.00
Thaw B., Esq., Pittsburg,	25.00	25.00

Thaw, J. C., Esq., Pittsburg,	100.00	100.00
Thaw, Mrs. William, Pittsburg,	50.00	50.00
Thomas, Amos R., M. D., Philadelphia,	10.00	10.00
Thomas, Charles M., M. D., Philadelphia,	60.00	60.00
Thomas, George C., Esq., Philadelphia,	100.00	100.00
Thomas, Mrs. George C., Philadelphia,	100.00	100.00
Thompson, Jas. G., M. D., New Brighton, Pa.,	2.00	2.00
Thompson, James H., M. D., Pittsburg, Pa.,	50.00	50.00
Thurston, Leon, M. D., Pittsburg, Pa.,	25.00	25.00
Tindall, Van R., M. D., Philadelphia,	25.00	25.00
Tomlin, R. Elmer, M. D., Philadelphia, Pa,	10.00	10.00
Tomlinson, W. H., M. D., Philadelphia,	10.00	10.00
Tortat, Albin E., M. D., Philadelphia,	5.00	5.00
Trexler, Col. H. C., Allentown, Pa.,	5.00	5.00
Ulrich, Mrs. and Miss, Elizabethtown, Pa.,	1.00	1.00
Ulrich, Silvester, M. D., Elizabethtown, Pa.,	5.00	5.00
Van Baun, Wm. W., M. D., Philadelphia, Pa.,	100.00	100.00
Vandergrift, Mrs. J. J., Pittsburg,	25.00	25.00
Van Deusen, Edwin H., M. D., Philadelphia,	5.00	5.00
Vandevort, Katherine, Pittsburg, Pa., (Dime Bank),	5.00	5.00
Van Lennep, Miss Rebecca R., Philadelphia, Pa.,	5.00	5.00
Van Lennep, William B., M. D., Philadelphia,	200.00	200.00
Vischer, Carl, M. D., Philadelphia,	25.00	25.00
Wainwright, Vilette, Pittsburg, Pa. (Dime Bank),	5.00	5.00
Walker, Mahlon M., M. D., Philadelphia,	10.00	10.00
Walter, Robert, M. D., Walter's Park, Pa.,	25.00	25.00
Waylan, Julia Gould, M. D., Philadelphia,	5.00	5.00
Walters, John W., M. D., Altoona, Pa.,	5.00	5.00
Weaver, C., Jr., Fox Chase, Pa.,	25.00	25.00
Weaver, Henry S., M. D., Philadelphia, Pa.,	10.00	10.00
Weaver, Miss Eleanor, Philadelphia,	5.00	5.00
Weaver, Miss Florence S., Philadelphia,	5.00	5.00
Weaver, Miss Bertha C., Philadelphia,	5.00	5.00
Weaver, Chandler, M. D., Philadelphia,	5.00	5.00
Weaver, Thurston Lane, Philadelphia,	5.00	5.00
Wendt, Charles I., M. D., Pittsburg, Pa.,	5.00	5.00
Westinghouse, Mrs. George, Pittsburg, Pa.,	1000.00	
White, Roland T., M. D., Pittsburg,	25.00	25.00
Whitney, Geo. I., Esq., Pittsburg, Pa.,	100.00	100.00
Willard, L. H., M. D., Allegheny, Pa.,	100.00	100.00
Williams, Thomas C., M. D., Philadelphia,	20.00	20.00
Williamson, Matthew S., M. D., Philadelphia,	25.00	
Wilson, Milton A., M. D., Erie, Pa.,	13.00	13.00
Wilson, Sylvia McQuitty, M. D., Pittsburg, Pa.,	10.00	10.00
Witzel, Joseph R., M. D., Philadelphia,	50.00	50.00
Wolfe, W. Wesley, M. D., Allegheny, Pa.,	5.00	5.00
Wooldridge, Julian, Pittsburg, Pa. (Dime Bank),	5.00	5.00
Wooldrigde, Ward, Pittsburg, Pa. (Dime Bank),	5.00	5.00
Yeagley, John H., M. D., York, Pa.,	5.00	5.00
Yoder, Daniel, M. D., Catassauqua, Pa.,	5.00	5.00
Ziegenfus, A. Frank, M. D., Philadelphia,	5.00	5.00

The amendments to the By-Laws, submitted in writing at the previous annual meeting, were then taken up for consideration. On motion, and by a two-thirds vote, Article V., Section 1, was amended so that it will read as follows: "The President shall preside at all meetings of the Society. He shall preserve order, appoint all committees, unless otherwise directed, and discharge all other duties, usually pertaining to a presiding officer, in accordance with the provisions of the Charter and these By-Laws. He shall be, ex-officio, a member of all standing committees of the Society. He shall not be eligible to two terms in succession."

On motion, and by a two-thirds vote, reconsideration of the action on the amendment to Article V., Section 1, was taken, and on motion, and by a two-thirds vote, the words "and chairman of the Board of Trustees" were inscribed after "a member of all standing committees," so that Article V., Section 1, now reads as follows: "The President shall preside at all meetings of the Society. He shall preserve order, appoint all committees, unless otherwise directed, and discharge all other duties, usually pertaining to a presiding officer, in accordance with the provisions of the Charter and these By-Laws. He shall be ex-officio, a member of all standing committees of the Society and Chairman of the Board of Trustees. He shall not be eligible to two terms in succession."

Article V., Section 7, was, on motion, and by a two-thirds vote amended so that it now reads as follows: "The Trustees shall have general supervision of the business of the Society, hold at least one meeting every year, and make a report at the annual session of the Society. The Trustees shall have the power to disburse all money belonging to the Society. No money shall be paid from the Treasury, except upon a written order, drawn on the Treasurer, and countersigned by the Chairman and Secretary of the Board of Trustees."

The amendment to Article V., Section 6, was not adopted, the article remaining the same as printed in the By-Laws.

On motion, and by a two-thirds vote, Article VI., Section 1, was amended by striking out the words "at 9 A. M.," so that it now reads as follows: "The annual meeting shall be held in the month of September on the days and at the place decided upon at the annual meeting next preceding."

Dr. Thomas L. Bradford presented the following:

REPORT OF THE NECROLOGIST.

Thomas C. Williams was born in Bangor, Me., in 1814, a son of the Rev. Thomas Williams and Sarah Cushman Williams. During his early life he taught school in Massachusetts, and at the age of nineteen was ready to enter college, but left home to do missionary work in the South, and to teach the colored race, but poor health prevented him from continuing this work. He returned to Maine and entered Bangor Theological Seminary, and graduated from that institution in 1845. On account of failing health he was compelled to abandon the ministry.

In 1847 he removed to Philadelphia, living with his brother, Dr. Theodore S. Williams, who was a widely known pioneer homœopathic physician at Germantown. Through his influence he became interested in medicine. He entered the Homœopathic Medical College of Pennsylvania in 1850, graduating therefrom in 1853. He first located in Kensington, where he practiced for several years, removing to 567 North Fifth street in 1860, where he resided until his death.

Dr. Williams was widely known to the profession of Philadelphia, having been a practitioner of homœopathy in that city for forty-six years. He was one of the organizers of the State Homœopathic Medical Society in 1866, and also of the Philadelphia County Homœopathic Society. He joined the American Institute of Homœopathy in 1871. He was a member of the Alumni Association of Hahnemann Medical College, and was from its opening, in 1877, a consulting physician of the Children's Homœopathic Hospital of Philadelphia. He was also a member of the Union League.

Dr. Williams had for many years a large practice and was well-known as a successful physician and as a Christian gentleman. He was in the habit of giving largely of his means for charitable purposes, and was greatly beloved by his patients for his kindness of heart.

For some months before his death he had been failing, and at the time of the meeting of this Society in Philadelphia, in September, 1899, Dr. B. W. James announced his feebleness, and the following resolution was adopted by the Society:

"The Society hears with regret of the illness of our esteemed fellow-member, Dr. T. C. Williams, of this city, and we desire to ex-

tend to him our sympathy in his sickness, and to express our hope that he may have a speedy and satisfactory recovery.

"Signed: Bushrod W. James, M. D., J. H. McClelland, M. D., C. C. Rinehart, M. D."

Dr. Williams lived but a few days afterwards, his death taking place on Sunday evening, October 1st, 1899, at the age of eighty-five years, after an illness of several months from the debility incident to old age. He was buried at Laurel Hill.

Isaac Garrett Smedley was born in Chester county, near West Chester, Pa., February 10th, 1855. He was the son of Thomas G. and Elizabeth J. Smedley. He received his earlier education at the Friends' High School at West Chester, afterwards entering Swarthmore College. He graduated from that institution in 1876, with the degree of B. S. He then took a summer course in Astronomy at the Cambridge Observatory of Harvard University, and the following year began the study of medicine at West Chester. In 1877 he entered Hahnemann Medical College of Philadelphia, graduating therefrom in 1880. For the next sixteen months he was resident physician at the Hahnemann Hospital, and in 1881 visited London, where he passed one year as clinical assistant in the Soho Hospital for Women, and in attendance at the Samaritan and other noted hospitals of the city. During his residence in England he attended the sessions of the International Medical Congress.

Upon his return to Philadelphia, in 1882, he was chosen assistant gynæcologist in the Hahnemann College Dispensary, was in charge 1890, 1891, 1892, and was clinical chief of the section of gynæcology from 1895 to the time of his death. He was also a gynæcologist to Hahnemann Hospital from 1887 to his death. He was Demonstrator of Gynæcology during the session 1891-'92, and Lecturer of Gynæcology in 1897-'98, 1898-'99. In 1896 Dr. Smedley refused the Chair of Obstetrics in the College. He was gynæcologist to St. Luke's Hospital of Philadelphia and consulting gynæcologist at the Camden Homœopathic Hospital and the Wilmington (Del.) Homœopathic Hospital.

He was a member of the State Board of Medical Examiners from its inception in 1894. He joined the American Institute of Homœopathy in 1897, this Society in 1880. He was also a member of the Philadelphia County Homœopathic Medical Society, the Philadelphia Medical Club, the Hahnemann Club, the Union League and the University Club.

In 1886 Dr. Smedley was married to Elizabeth K. Hallowell, a granddaughter of Benjamin Hallowell, a noted educator and minister of the Society of Friends, of which Dr. Smedley was also a member. His widow and two daughters survive him.

The cause of his death was singularly distressful. On Friday, December 1, 1899, as he was hurrying to board a train which leaves Bryn Mawr, Pa., a suburb of Philadelphia, at 1:18 P. M., for Broad Street Station, he was unable to retain his grasp of a hand-rail, and being turned about was almost instantly killed by his head striking upon an edge of the steps of the adjoining car. He fell upon the station platform unconscious and died a few minutes later in the waiting room. Dr. Smedley went to Bryn Mawr to visit a patient of Dr. W. C. Powell, and was met at the station by him. About an hour later Dr. Powell returned with Dr. Smedley to the station and the two physicians remained in the carriage to chat. They arrived three minutes before the schedule time for the leaving of the train, and Dr. Smedley soon looking at his watch found it showed 1:18.

"I guess I'd better get out," he said, and suited the action to the word. He had in one hand a heavy satchel containing surgical instruments and his overcoat was on his arm. He ran towards the train, for it was in motion, and had moved about two car lengths In all there were three coaches, and on the rear platform of the second coach he gained a footing. But one hand caught the rail, and cumbered by the satchel and the coat, he swung backward as on a pivot. His head struck upon the step of the third car and, insensible, he rolled upon the station platform. The train was at once stopped and backed to the station. The doctor was carried into the waiting room, where in a few minutes he breathed his last. Not until Dr. Powell arrived at his home was he aware of the accident. He was notified by telephone and immediately left his house, running across the fields. He reached the station three minutes after Dr. Smedley died.

Dr. Smedley's death was due to a fracture of the skull. He had been in excellent health and no other injury was noticeable than the gash that was cut in the back of his head. His coat was torn as a result of his being rolled upon the platform, and his satchel, it was found, had one end of the handle torn from its fastenings.

His haste was from the fact that he was due at Hahnemann Hospital at 2 o'clock, where he was to perform an operation before his clinic of students. It was a very great shock to them when, in-

stead of their beloved teacher, news came through the hospital telephone of his sad death.

The body was taken to an undertaker's establishment in Ardmore to await action by the Montgomery county coroner.

The funeral was held on Monday, December 4, at 2 o'clock, according to the simple and impressive ceremony of the Society of Friends. Hundreds of friends of the deceased physician, many of them prominent in the medical profession, viewed the remains as they lay in the handsome black covered casket at his late home at 1705 Arch street.

Hahnemann College, of whose faculty Dr. Smedley was a member, was closed during the day. The members of the faculty and students assembled in the college at 1:30 o'clock, and marched in a body to the Friends' Central Meeting House, at Fifteenth and Race streets where the funeral services were held. Addresses were made by Dr. Pemberton Dudley, on behalf of the Hahnemann College; Prof. Edward H. Magill, former President of Swarthmore College; R. G. Dork, Samuel S. Ash, and Thomas Fisher.

The honorary pall-bearers were: Drs. Pemberton Dudley, Charles M. Thomas, Augustus Korndoerfer, John E. James, Henry C. Chisholm, of Huntingdon, Pa.; Edward W. Mercer, Louis P. Posey, William W. Van Baun, P. Sharples Hall, Augustus Korndoerfer, Jr., Halton I. Jessup, Oliver S. Haines. The ushers were: Dr. William Speakman, of Swarthmore; Arthur Collins, Charles Paxson, Ferris W. Price, J. Russell Hayes, and William J. Hull, of the Swarthmore College faculty. The interment was at Fairhill cemetery.

Resolutions of respect were passed by the societies of which he was a member, and great regret was expressed by the students of the college and by his fellow-teachers, as well as by his numerous professional friends and patients, that so useful and valuable a life should end so sadly.

Pearl Starr, M. D., was born in Cincinnati, Ohio, August 29, 1851. She was the daughter of Dr. David L. Starr and Sarah Harper Starr. After her course in the public schools was added a high school course at Athens, Ohio, from which institution she graduated at the age of sixteen. She was taught music and languages by private teachers, who were professors in the University. Her medical education was commenced with instruction from her father, who became her medical tutor. She attended one course at the Buffalo Medical College,

followed by two years in the Homœopathic Hospital College of Cleveland, from which institution she graduated in 1883, winning a prize for the best essay.

She settled in Allegheny City, opening an office on Arch street, where she remained for one year. She then located at Bellevue, becoming associated in practice with her father until his retirement, when she succeeded to his business.

She joined the American Institute of Homœopathy in 1890; was a member of the Allegheny County Homœopathic Society and of the Woman's Hom. Med. Society of Pittsburg. She joined this Society in 1889. She was also greatly interested in the cause of temperance and was a member of several organizations, in which she was a zealous worker. She was at the time of her death superintendent in a department of the W. C. T. U. She was also a member of the Methodist Protestant church, of Bellevue.

The cause of her death was an hematoma-salpinx of the left broad ligament, beginning seven years ago, but not disturbing her general health until a year previous to her decease. For the last year of her life she suffered intensely, and thought the growth was malignant. While naturally fearing grave results from her disease, yet she kept bravely at work until April 1st of the present year. About four years ago she struck her side against a table while hurriedly taking a burning lamp from the room. It was thought that this injury was a predisposing cause of the final illness.

A short time before her death she went to the Pittsburg Homœopathic Hospital, where an operation was at her urgent request performed but two days before she passed away.

The funeral occurred on July 24th, being attended by her professional friends and numerous patients, the pall-bearers being at her request selected from members of the Allegheny County Homœopathic Medical Society.

Dr. Millie J. Chapman, who was her attending physician, thus writes of her: "She was an earnest, good woman, devoted to the interests of her patients, unobtrusive and kindly. She was patient and bravely met the end."

At her own request the text selected for her funeral was that beautiful one from St. Luke: "Be ye therefore ready also; for the Son of Man cometh at an hour when ye think it not."

One who knew her intimately says: Doctor Starr was of a retiring nature and never forgot that she, first of all, was a lady. It was this that made her so dear to her friends and those with whom she

came in contact. She won her way where others would have tried to force theirs, and some of her best friends and patients were from among those who were opposed to woman as a practitioner.

At the time of her operation she was as cool as though it were an every-day occurrence. She informed me of its dangerous nature, and said that she had only about one chance out of a hundred of pulling through. Gave all the necessary directions as to her funeral; then went as calmly to the operating table as though to her bed. The afternoon of the evening that she passed away I saw her count her pulse without any more excitement than she would have shown in her practice.

In her home life she was always kind and never seemed to think of herself; it was always someone else. I never heard her say an unkind word.

On motion the subject of the licensing of midwives, which had been referred to the Committee on Legislation at the last session, was placed in the hands of a committee composed of Drs. E. M. Gramm, W. J. Martin, R. E. Tomlin, Theodore M. Johnson, Theodore Sureth, O. S. Haines and A. P. Bowie. After considering the subject the committee presented the following report:

REPORT OF COMMITTEE ON LICENSING MIDWIVES.

Your committee would report that it does not recommend any legislation for licensing midwives, but suggests that the Legislative Committee draft a bill, in conjunction with the old school State Society, looking either to the abolishing or regulating the practice of midwifery by midwives or licensing them.

On motion, the report was adopted and the Legislative Committee was instructed to carry out the suggestions made in the report.

On motion, the Publication Committee was authorized to offer for sale to members of the Society in good standing old editions of the Transactions at a price not less than fifty (50) cents per volume.

The election of officers, which was conducted by Drs. Trimble Pratt and J. R. Mansfield as tellers, resulted in the selection of Dr. Horace B. Ware, of Scranton, as President; Dr. H. L. Northrop, of Philadelphia, as First Vice President; Dr. W. J. Martin, of Pittsburg, as Second Vice President; Dr. George B. Moreland, of Pittsburg, as Recording Secretary; Dr. E. M. Gramm, of Philadelphia, as Corresponding Secretary; Dr. Ella D. Goff, of Allegheny, as Treasurer; Dr. T. L. Bradford, of Philadelphia, as Necrologist; Dr.

E. H. Pond, of Pittsburg, as Censor, to serve for three years, and Drs. H. B. Ware, of Scranton; Dr. I. B. Gilbert, of Philadelphia, and Dr. W. W. Van Baun, of Philadelphia, as Trustees, to serve for three years.

On motion, Dr. E. B. Nash, of New York, was elected an honorary member, and Dr. J. C. Burnett, of London, a corresponding member.

A vote of thanks was extended to the Northeastern Society for the entertainment offered the State Society at this meeting.

A vote of thanks was given to the President and other officers of the Society for the excellent manner characterizing the conduction of their several offices.

A vote of thanks was extended the press for the very excellent and voluminous reports of the meeting.

A vote of thanks was given Drs. Henry Stambach, Bukk G. Carleton and W. Louis Hartman for the excellent papers presented.

On motion, the invitation extended by the Allegheny County Homœopathic Medical Society to hold the next annual meeting in Pittsburg was accepted.

The Board of Censors reported favorably on the following names and recommended them for election as active members, and they were thereupon elected:

H. Bierman, M. D., Bloomsburg.
Theo. L. Chase, M. D., Philadelphia.
J. A. Kressly, M. D., New Tripoli.
Thomas Minahan, M. D., Carnegie.
John L. Peck, M. D., Scranton.
E. T. Prizer, M. D., Lancaster.
Walter W. Seibert, M. D., Easton.
C. W. Simmons, M. D., Philadelphia.
E. S. Snyder, M. D., Lancaster.

The President announced the appointment of the following

COMMITTEES.

Committee on Legislation.—L. H. Willard, M. D., Chairman; Associates, Drs. Clarence Bartlett, A. P. Bowie, Edward Cranch, Pemberton Dudley, E. M. Gramm, J. C. Guernsey, John E. James, Augustus Korndoerfer, Sr., W. J. Martin, J. H. McClelland, Z. T. Miller, H. F. Schantz, C. S. Schwenk, C. P. Seip, W. B. Van Lennep.

Committee on Organization, Registration and Statistics.—George

B. Moreland, M. D., Chairman; Associates, Drs. C. F. Bingaman, E. M. Gramm.

Committee on Publication.—E. M. Gramm, M. D., Chairman; Associates, Drs. Ella D. Goff, George B. Moreland.

DELEGATES TO SOCIETIES.

American Institute of Homœopathy.—Drs. Z. T. Miller, Millie J. Chapman, B. W. James.

Delaware State Society.—Drs. Clarence Bartlett, T. J. Gramm, Julia G. Waylan.

Interstate Committee of the American Institute of Homœopathy.—Drs. W. C. Goodno, H. B. Ware.

Maryland State Society.—Drs. J. C. Guernsey, T. M. Johnson, W. W. Van Baun.

Massachusetts State Society.—Drs. W. B. Van Lennep, I. B. Gilbert, J. H. Closson.

New Jersey State Society.—Drs. W. H. Seibert, E. R. Snader, C. V. Vischer.

New York State Society.—Drs. R. W. McClelland, R. P. Mercer, Charles Mohr.

Ohio State Society.—Drs. C. P. Seip, H. W. Fulton, P. S. Duff.

Southern Institute of Homœopathy.—Drs. W. J. Martin, W. B. Van Lennep, C. V. Vischer.

West Virginia State Society.—Drs. C. H. Hofman, R. S. Marshall, W. D. King.

SECTIONS.

Clinical Medicine.—Dr. S. W. S. Dinsmore, Chairman; Associates, Drs. S. G. A. Brown, Bushrod W. James.

Gynæcology.—J. A. Bullard, M. D., Chairman; Associates, Drs. B. F. Betts, Millie J. Chapman, Sarah J. Coe, T. J. Gramm, C. H. Hofman, J. E. James, T. M. Johnson, A. A. Lindabury, R. S. Marshall, J. H. McClelland, J. H. Thompson, R. E. Tomlin.

Materia Medica.—W. A. Seibert, M. D., Chairman; Associates, Drs. A. J. Bittner, A. P. Bowie, T. H. Carmichael, Edward Cranch, A. L. Kistler, Aug. Korndoerfer, Sr., C. S. Middleton, Charles Mohr, C. S. Raue, C. S. Schwenk, G. W. Smith, R. T. White, H. H. Wilford.

Obstetrics.—W. F. Edmundson, M. D., Chairman; Associates, Drs. Mary A. Cook, Wm. D. King, D. C. Kline, A. Korndoerfer, Jr.,

A. B. Lichtenwalner, E. W. Mercer, G. B. Moreland, J. B. McClelland, Margaret H. Schantz, F. R. Schmucker.

Ophthalmology, Otology and Laryngology.—G. A. Mueller, M. D., Chairman; Associates, Drs. W. W. Blair, H. B. Bryson, G. J. Palen, I. G. Shallcross, Wm. Spencer, C. M. Thomas, H. B. Ware, H. S. Weaver.

Pædology.—D. S. Kistler, M. D., Chairman; Associates, Drs. H. Bierman, W. H. Bigler, F. W. Boyer, Anna C. Clarke, W. G. Dietz, J. R. Mansfield, W. J. Martin, C. W. Perkins, R. S. Piper, C. W. Simmons, Theodore Sureth.

Pathology and Pathological Anatomy.—W. C. Goodno, M. D., Chairman; Associates, Drs. Clarence Bartlett, W. D. Bayley, W. D. Carter, T. S. Dunning, I. B. Gilbert, T. P. Gittens, P. Sharples Hall, W. K. Ingersoll, E. H. Van Deusen.

Sanitary Science.—S. G. Godshall, M. D., Chairman; Associates, Drs. J. D. Boileau, Isaac Crowther, A. C. Heritage, E. H. Hill, A. F. Merrell, W. C. Powell, Trimble Pratt, Chandler Weaver, D. B. Umstead.

Surgery.—H. L. Northrop, M. D., Chairman; Associates, Drs. L. T. Ashcraft, F. C. Benson, T. L. Chase, J. W. Coolidge, D. P. Maddux, J. L. Peck, S. M. Rinehart, H. F. Schantz, C. P. Seip, W. G. Steele, Walter Strong, L. W. Thompson, G. A. Van Lennep, W. B. Van Lennep, C. V. Vischer, L. H. Willard.

By resolution of the Board of Trustees the following amendments to the By-Laws were offered:

Strike out Section 4 of Article VIII.

Amend Article V., Section 1, by adding after the word "succession" the following: "On assuming office, it shall be his duty to appoint a Chairman for each of the Sections designated in Article VIII., Section 1; and the Chairman, in conjunction with the President, shall select his Associates."

Dr. J. R. Mansfield presented the following amendment:

Amend Article VII. by substituting for the word "five" after the words "the sum of," the word "three," so that the Article shall read "Active members shall pay annually, in advance, the sum of three dollars towards defraying the expenses of the Society. Any member who shall fail to pay his annual dues for three successive years shall be dropped from the roll of members, after having been notified by the Corresponding Secretary of the forfeiture of his membership. The published proceedings of the Society will be furnished only to those members who are not in arrears for dues."

OFFICERS OF THE SOCIETY FROM ITS ORGANIZATION TO THE PRESENT TIME.

PRESIDENTS.

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1867. W. WILLIAMSON, M. D.,
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1871. M. COTE, M. D.,
1872. J. H. MARSDEN, M. D.,
1873. B. W. JAMES, M. D. (February),
1873. J. F. COOPER, M. D. (October),
1874. C. A. STEVENS, M. D.,
1875. R. J. McCLATCHEY, M. D.,
1876. J. E. JONES, M. D.,
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1899. B. F. BETTS, M. D.,
1900. C. C. RINEHART, M. D.

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1871. R. FAULKNER, M. D.,
1872. H. N. GUERNSEY, M. D.,
1873. M. PRESTON, M. D. (February),
1873. M. FRIESE, M. D. (October),
1874. I. LEFEVER, M. D.,
1875. J. E. JONES, M. D.,
1876. J. C. BURGHER, M. D.,
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1883. HUGH PITCAIRN, M. D.,
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1888. W. B. TRITES, M. D.,
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1892. F. R. SCHMUCKER, M. D.,
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1897. W. H. KEIM, M. D.,
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1899. A. P. BOWIE, M. D.,
1900. E. H. HILL, M. D.

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1870. J. H. McCLELLAND, M. D.,
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1872. S. F. CHARLTON, M. D.,
1873. J. C. BURGHER, M. D. (February),
1873. H. R. FETTERHOFF, M. D. (October),
1874. W. F. SPETH, M. D.,
1875. H. N. MARTIN, M. D.,
1876. J. E. JAMES, M. D.,
1877. J. E. JAMES, M. D.,
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1879. L. M. ROSSEAU, M. D.,
1880. J. W. ALLEN, M. D.,
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1882. J. B. WOOD, M. D.,
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1884. H. DETWILLER, M. D.,
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1897. H. B. WARE, M. D.,
1898. EDWARD CRANCH, M. D.,
1899. ANNA C. CLARKE, M. D.,
1900. R. P. MERCER, M. D.

RECORDING SECRETARIES.

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1873-1878. M. M. WALKER, M. D.,
1879-1882. Z. T. MILLER, M. D.,
1883. T. M. STRONG, M. D.,
1884, 1885. C. BARTLETT, M. D.,
1886, 1887. H. F. IVINS, M. D.,
1888, 1889. J. H. CLOSSON, M. D.,
1890-1894. J. R. HORNER, M. D.,
1895. E. M. GRAMM, M. D.,
1896-1900. G. B. MORELAND, M. D.

CORRESPONDING SECRETARIES.

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1873-1875. P. DUDLEY, M. D.,
1876-1879. J. C. GUERNSEY, M. D.,
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1886-1888. C. BARTLETT, M. D.,
1889-1894. E. R. SNADER, M. D.,
1895. J. R. HORNER, M. D.,
1896-1900. E. M. GRAMM, M. D.

TREASURERS.

1866. D. COWLEY, M. D.,
1867. H. H. HOFMANN, M. D.,
1868. W. WILLIAMSON, M. D.,
1870. W. J. BLAKELY, M. D.,
1871-1873 (February) O. B. GAUSE, M. D.,
1873 (October) and 1874. R. J. McCLATCHEY, M. D.,
1875-1899. J. F. COOPER, M. D.,
1900. ELLA D. GOFF, M. D.

NECROLOGISTS.

1872-1883. W. R. CHILDS, M. D.,
1884. M. M. WALKER, M.D.,
1885-1889. W. R. CHILDS, M. D.,
1890-1894. W. J. MARTIN, M. D.,
1895, 1896. T. S. DUNNING, M.D.,
1897-1900. T. L. BRADFORD, M. D.

LIST OF MEMBERS.

1899—Adams, T. Louis, M. D., 1831 Chestnut street, Philadelphia.
1899—Arthur, Alexander B., M. D., 12th and Spruce streets, Phila.
1899—Artz, Jerome L., M. D., Camden, N. J.
1898—Ashcraft, Leon T., M. D., 1833 Chestnut street, Philadelphia.
1892—Baier, George F., M. D., Norwood.
1889—Baily, A. W., M. D., 1809 Pacific Ave., Atlantic City, N. J.
1896—Baker, Albra W., M. D., Emporium.
1899—Baker, Daniel J., M. D., 1706 N. 19th street, Philadelphia.
1898—Barnes, Alonzo M., M. D., 3517 N. Broad street, Philadelphia.
1881—Bartlett, Clarence, M. D., 1506 Arch street, Philadelphia.
1889—Bayley, Weston D., M. D., 1438 Poplar street, Philadelphia.
1897—Berlinghof, George J., M. D., 1408 Capouse Ave., Scranton.
1875—BETTS, B. F., M. D., 1609 Girard Ave., Philadelphia.
1886—Bier, P. A., M. D., 4200 Butler street, Pittsburg.
1900—Bierman, H., M. D., Bloomsburg.
1892—Bigelow, W. S., M. D., Phillipsburg.
1872—BIGLER, W. H., M. D., 118 N. 17th street, Philadelphia.
1873—BINGAMAN, C. F., M. D., 922 Penn Ave., Pittsburg.
1896—Birch, J. P., M. D., 3801 Powelton Ave., Philadelphia.
1894—Bittner, Albert Jacob, M. D., Allentown.
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1892—Boileau, John D., M. D., 804 W. Lehigh Ave., Philadelphia.
1892—Books, B. F., M. D., 1117 Twelfth Ave., Altoona.
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1884—Boyd, G. S., M. D., Beaver Falls.
1880—Boyd, J. S., M. D., New Brighton.
1882—Boyer, Francis W., M. D., Pottsville.
1894—Bradford, Thomas Lindsley, M. D., 1862 Frankford Ave., Philadelphia.
1883—Branson, Mary, M. D., 1719 Arch street, Philadelphia.
1896—Brewer, Mary, M. D., 330 E. Chelten Ave., Gtn., Philadelphia.
1895—Brewster, F. D., M. D., 309 Jefferson Ave., Scranton.
1898—Brickley, E. N., M. D., York.
1891—Brown, C. H., M. D., 1824 Diamond street, Philadelphia.

1898—Brown, C. Sheble, M. D., 3046 Frankford Ave., Philadelphia.
1894—Brown, S. G. A., M. D., Shippensburg.
1891—Brown, William K., M. D., 1311 N. Broad street, Philadelphia.
1893—Bryson, H. Ballou, M. D., 524 Penn Ave., Pittsburg.
1886—Bulick, T. M., M. D., 317 N. Second street, Harrisburg.
1877—BULLARD, J. A., M. D., 200 S. Main street, Wilkesbarre.
1881—Bunting, H. M., M. D., 521 Swede street, Norristown.
1888—Burchfield, S. E., M. D., 803 Ligonier street, Latrobe.
1866—BURGHER, J. C., M. D., 960 Penn Ave., Pittsburg.
1891—Burlingame, F. W., M. D., 116 Sixth Ave., McKeesport.
1896—Caley, Joseph M., M. D., 1513 Green street, Philadelphia.
1898—Calhoun, John C., M. D., Pittsburg.
1888—Carmichael, T. H., M. D., 7127 Germantown Ave., Phila.
1897—Carter, Woodward D., M. D., 1533 S. 15th street, Phila.
1898—Challinor, S. Boyd, M. D., 311 Oakland Ave., Pittsburg.
1875—CHAPMAN, MILLIE J., M. D., 804 Penn Ave., Pittsburg.
1900—Chase, Theo L., M. D., 1687 N. 54th street, Philadelphia.
1888—Chisolm, H. C., M. D., 528 Penn street, Philadelphia.
1885—Christine, G. Maxwell, M. D., 2043 N. 12th street, Phila.
1899—Clark, Edward P., M. D., Connellsville.
1893—Clark, George H., M. D., 4 Walnut Lane, Germantown, Phila.
1889—Clarke, Anna C., M. D., 426 Adams Ave., Scranton.
1886—Closson, J. H., M. D., 53 W. Chelten Ave., Germantown, Philadelphia.
1883—Coe, Sarah J., M. D., 92 N. Franklin street, Wilkesbarre.
1894—Conarroe, Thomas H., M. D., 872 N. 26th street, Philadelphia.
1895—Cook, W. C., M. D., 327 Grandview Ave., Pittsburg.
1894—Cooke, Mary A., M. D., 2113 N. 18th street, Philadelphia.
1889—Coolidge, J. W., M. D., 334 Washington Ave., Scranton.
1887—Cooper, John, M. D., 54 Arch street, Allegheny.
1894—Cooper, Peter, M. D., 502 Delaware Ave., Wilmington, Del.
1895—Cooper, Wm. H., M. D., Oakmont.
1882—Cranch, Edw., M. D., 109 W. Ninth street, Erie.
1898—Cresson, Charles C., M. D., 5909 Green street, Gtn., Phila.
1885—Crowther, Isaac, M. D., 143 E. 7th street, Chester.
1891—Davis, B. L., M. D., Bellevue.
1897—Dehoff, J. W., M. D., York, Pa.
1866—DETWILLER, JOHN J., M. D., 52 Centre Square, Easton.
1893—Detwiller, W. K., M. D., Easton.
1886—Dietz, W. G., M. D., 21 N. Vine street, Hazleton.
1878—DINSMORE, S. W. S., M. D., 60 N. Main street, Sharpsburg.

1895—Doyle, H. H., M. D., 485 Fifth Ave., Pittsburg.
1891—Drake, J. C. Merle, M. D., 720 Sassafrass street, Erie.
1867—DUDLEY, PEMBERTON, M. D., 1405 N. 16th street, Phila.
1878—DUFF, P. S., M. D., Great Belt.
1882—Du Four, W. M., M. D., 755 W. Third street, Williamsport.
1881—Dunning, T. S., M. D., 1328 N. 15th street, Philadelphia.
1893—Ealer, Percy H., M. D., 815 N. 24th street, Philadelphia.
1873—EDMUNDSON, W. F., M. D., 1321 Fifth Ave., Pittsburg.
1891—Ely, J., M. D., Washington.
1896—Esrey, L. K., M. D., 1642 Pine street, Philadelphia.
1895—Fitz, W. H. A., M. D., 819 N. 25th street, Philadelphia.
1884—Fleming, R. K., M. D., 6224 Station street, Pittsburg.
1892—Flint, Harvey E., M. D., West 11th street, Erie.
1892—Flint, John F., M. D., 1112 Peach street, Erie.
1873—FULTON, H. W., M. D., 5949 Penn Ave., Pittsburg.
1898—Gann, G. W., M. D., DuBois.
1892—Gerberich, D. P., M. D., Lebanon.
1886—Gerhart, Jos. M., M. D., 1127 Mt. Vernon street, Phila.
1879—GETZE, G. M., M. D., Tarentum.
1891—Gilbert, Irwin B., M. D., 2027 Columbia Ave., Philadelphia.
1894—Gittens, Theodore P., M. D., 1716 Diamond street, Phila.
1899—Godshall, S. G., M. D., Edge Hill.
1891—Goff, Ella D., M. D., 10 N. Diamond street, Allegheny.
1875—GOODNO, W. C., M. D., 1724 Chestnut street, Philadelphia.
1883—Gramm, Edward, M. D., 1833 Chestnut street, Philadelphia.
1867—GRAMM, G. E., M. D., 846 N. Broad street, Philadelphia.
1883—Gramm, Theo. J., M. D., 846 N. Broad street, Philadelphia.
1895—Gregg, Edw. R., M. D., 334 S. Highland Ave., Pittsburg.
1889—Gregory, G. W., M. D., Troy.
1888—Griffith, Louis B., M. D., 2526 Ridge Ave., Philadelphia.
1881—Griffith, Silas, M. D., 1431 Girard Ave., Philadelphia.
1877—GRIFFITH, W. M., M. D., 1827 N. 17th street, Philadelphia.
1874—GUERNSEY, J. C., M. D., 1923 Chestnut street, Phila.
1867—GUMPERT, B. BARTON, M. D., 840 Franklin street, Phila.
1886—Gundlach, F. C., M. D., 1722 Sarah street, Pittsburg.
1894—Haas, George H., M. D., Allentown.
1885—Haines, O. S., M. D., 137 N. 15th street, Philadelphia.
1896—Hall, P. Sharples, M. D., 1604 Arch street, Philadelphia.
1887—Haman, W. A., M. D., 122 N. 8th street, Reading.
1898—Hammond, W. Wilson, M. D., 1420 Poplar street, Phila.
1883—Hancock, Jos., M. D., 1639 Columbia Ave., Philadelphia.

1899—Harner, D. W., M. D., New Holland.
1888—Harner, John E., M. D., 117 S. 5th street, Reading.
1891—Harpel, F. E., M. D., Danville.
1884—Harris, D. R., M. D., 41 N. Jefferson street, New Castle.
1892—Hassler, J. Wyllis, M. D., 1503 Poplar street, Philadelphia.
1883—Hassler, W. A., M. D., 105 N. 8th street, Allentown.
1893—Heath, L. R., M. D., Mercer.
1895—Heilner, H. F., M. D., Scranton.
1883—Helfrich, J. H., M. D., Allentown.
1899—Hendrixson, Lewis H., M. D., New Holland.
1892—Heritage, A. C., M. D., Jenkintown.
1873—HERRON, C. D., M. D., 3505 Butler street, Pittsburg.
1892—Hill, E. H., M. D., Tunkhannock.
1882—Hofman, C. H., M. D., 510 S. Highland Ave., Pittsburg.
1883—Holben, M. J., M. D., Slatington.
1892—Holsberg, W. H., M. D., Lebanon.
1883—Horner, J. Richey, M. D., 275 Prospect street, Cleveland, O.
1889—Hoy, H. K., M. D., 1203 Fourteenth street, Altoona.
1880—Humes, J. R., M. D., Hollidaysburg.
1886—Ingersoll, W. K., M. D., 4008 Chestnut street, Philadelphia.
1892—Irvin, Thomas A., M. D., Franklin.
1866—JAMES, BUSHROD W., M. D., 1719 Green street, Phila.
1867—JAMES, JOHN E., M. D., 1521 Arch street, Philadelphia.
1889—Jamison, M. R., M. D., Greensburg.
1892—Jessup, H. I., M. D., 1829 Arch street, Philadelphia.
1881—Johnson, Theodore M., M. D., 200 Susquehanna Ave., Pittston.
1892—Karsner, Charles W., M. D., 1320 S. Broad street, Phila.
1881—Karsner, Daniel, M. D., 205 Tulpehocken street, Germantown.
1889—Kase, Edmund H., M. D., 1325 Girard Ave., Philadelphia.
1891—Kaufman, John, M. D., Hazleton.
1896—Keelor, J. G., M. D., 48th and Baltimore Ave., Philadelphia.
1894—Kehler, B. Frank, M. D., 1708 N. 8th street, Philadelphia.
1885—Keim, William H., M. D., 1716 N. 18th street, Philadelphia.
1892—Kistler, A. L., M. D., N. E. Cor. 9th and Linden streets, Allentown.
1897—Kistler, D. S., M. D., Wilkesbarre.
1891—Kline, D. C., M. D., 5th and Chestnut streets, Reading.
1891—Knauer, J. C., M. D., 233 S. 9th street, Reading.
1899—Knerr, Bayard, M. D., 12th and Spruce streets, Philadelphia.
1877—KNERR, C. B., M. D., 1833 Chestnut street, Philadelphia.

1872—KORNDŒRFER, AUGUSTUS, SR., M. D., 1728 Green street, Philadelphia.
1896—Korndœrfer, Augustus, Jr., M. D., 142 N. 18th street, Phila.
1900—Kressly, J. A., M. D., New Tripoli.
1896—Krusen, Edward A., M. D., Collegeville.
1894—Lawrence, F. Mortimer, M. D., 1601 Girard Ave., Phila.
1888—Layman, Alfred, M. D., 1630 N. 18th street, Philadelphia.
1887—Leake, E. N., M. D., Butler.
1884—Leckie, J. W., M. D., Hazleton.
1894—Lentz, Levi R., M. D., Fleetwood.
1894—Lichtenwalner, A. B., M. D., 2435 N. 7th street, Philadelphia.
1895—Lindabury, A. A., M. D., Scranton.
1896—Lyle, William Howard, M. D., 1833 Master street, Phila.
1868—MACFARLAN, MALCOLM, M. D., 1805 Chestnut street, Philadelphia.
1893—Macfarlan, Duncan, M. D., 3924 Chestnut street, Philadelphia.
1886—Maddux, D. P., M. D., 700 Madison street, Chester.
1878—MALIN, WILLIAM H., M. D., 8408 Germantown Ave., Chestnut Hill, Philadelphia.
1892—Mansfield, Harry K., M. D., 19 W. Chelten Ave., Germantown, Philadelphia.
1881—Mansfield, J. R., M. D., 4852 Germantown Ave., Philadelphia.
1891—Marks, William F., M. D., 118 N. 9th street, Reading.
1885—Marsden, Biddle R., M. D., Chestnut Hill, Philadelphia.
1883—Marshall, Anna M., M. D., 1420 Chestnut street, Philadelphia.
1891—Marshall, R. S., M. D., 424 Shady Ave., Pittsburg.
1899—Martin, Robert W., M. D., 1831 Chestnut street, Philadelphia.
1877—MARTIN, W. J., M. D., 1712 Carson street, S. S., Pittsburg.
1878—MAURER, J. M., M. D., Washington.
1891—McCauley, J. C., M. D., 128 Connecticut street, Rochester.
1879—M'CLELLAND, J. B., M. D., 409 Penn Ave., Pittsburg.
1867—M'CLELLAND, J. H., M. D., 5th and Wilkins Ave., Pittsburg.
1884—McClelland, R. W., M. D., 5th and Wilkins Ave., Pittsburg.
1883—McClure, Eliza H. Lang, M. D., 1919 Wallace street, Philadelphia.
1893—McCracken, William, M. D., 2110 Carson street, Pittsburg.
1888—Mercer, Edward W., M. D., 1705 Arch street, Philadelphia.
1871—MERCER, ROBERT P., M. D., 223 W. 3d street, Chester.
1896—Merrell, A. F. M. D., Hallstead.
1871—MIDDLETON, CALEB S., M. D., 1523 Girard Ave., Phila.

1887—Millen, J. C., M. D., 911 Downing Ave., Denver, Col.
1887—Miller, Z. T., M. D., 2013 Carson street, S. S., Pittsburg.
1900—Minaham, Thomas, M. D., Carnegie.
1883—Mitchell, J. N., M. D., 1505 Spruce street, Philadelphia.
1875—MOHR, CHARLES, M. D., 1823 Green street Philadelphia.
1893—Monroe, J. E., M. D., Orange, Mass.
1893—Moon, S. B., M. D., 1314 Eighth Ave., Beaver Falls.
1893—Moreland, George B., M. D., 1321 Fifth Ave., Pittsburg.
1891—Mueller, G. A., M. D., Empire Bldg., Liberty Ave. and 5th street, Pittsburg.
1888—Murdock, Robert, M. D., 160 S. Main street, Wilkesbarre.
1894—Myers, Charles Elwood, M. D., 170 Green Lane, Manayunk, Philadelphia.
1866—NEVILLE, W. H. H., M. D., 1833 Wallace street, Philadelphia.
1893—Northrop, H. L., M. D., 1729 Arch street, Philadelphia.
1891—Norton, Claude R., M. D., 700 N. 40th street, Philadelphia.
1898—Palen, Gilbert J., M. D., Walnut Lane and Germantown Ave., Philadelphia.
1896—Palmer, Charles R., M. D., West Chester.
1884—Parker, G. W., M. D., 1404 S. 6th street, Philadelphia.
1883—Parker, T. Elwood, M. D., Woodbury, N. J.
1870—PARSONS, ANSON, M. D., Springboro.
1881—Parsons, E. C., M. D., 275 Walnut street, Meadville.
1897—Paxson, O. H., M. D., 123 N. 16th street, Philadelphia.
1880—Peach, William, M. D., 58 Monterey street, Allegheny.
1900—Peck, John L., Scranton.
1881—Perkins, C. W., M. D., 403 Broad street, Chester.
1894—Peters, J. Elwood, M. D., Jenkintown.
1883—Pettengill, Eliza F., M. D., 300 N. 10th street, Philadelphia.
1891—Phillips, Joseph R., M. D., 15 E. 8th street, Erie.
1897—Piper, R. L., M. D., Tyrone.
1880—Pitcairn, Hugh, M. D., 206 State street, Harrisburg.
1895—Pitcairn, R. C., M. D., 5518 Ellsworth Ave., Pittsburg.
1894—Pollock, Martha H., M. D., 210 Pine street, Harrisburg.
1891—Pond, Edward H., M. D., 2041 Wylie Ave., Pittsburg.
1886—Posey, L. P., M. D., 1435 Walnut street, Philadelphia.
1896—Powel, Franklin, M. D., Chester.
1883—Powell, W. C., Jr., M. D., Bryn Mawr.
1871—PRATT, TRIMBLE, M. D., Media.
1900—Prizer, E. L., M. D., Lancaster.

1896—Pursell, James P., M. D., Easton.
1897—Raue, C. Sigmund, M. D., 121 N. 10th street, Philadelphia.
1883—Reading, J. H., M. D., 1811 Green street, Philadelphia.
1886—Reading, L. W., M. D., 1629 Green street, Philadelphia.
1888—Reading, Thomas, M. D., Hatboro.
1896—Redman, John L., M. D., 1336 Spruce street, Philadelphia.
1886—Reeves, Joseph M., M. D., 1609 Mt. Vernon street, Phila.
1896—Ridge, Jonathan T., M. D., 1617 N. 7th street, Philadelphia.
1878—RINEHART, C. C., M. D., 4637 Centre Ave., Pittsburg.
1894—Rinehart, S. M., M. D., 293 Western Ave., Allegheny.
1895—Roberts, C. W., M. D., Scranton.
1880—Robson, J. W., M. D., 350 Winebiddle Ave., Pittsburg.
1883—Rosseau, L. G., M. D., 118 S. Negley Ave., Pittsburg.
1894—Rotzell, W. E., M. D., Narberth.
1888—Sandel, J. H., M. D., 49 Center Ave., Plymouth.
1872—SARTAIN, HARRIET, J., M. D., 212 W. Logan Square, Philadelphia.
1896—Schantz, Henry F., M. D., 402 N. 5th street, Reading.
1892—Schantz, M. Margaret Hassler, M. D., Reading.
1874—SCHMUCKER, F. R., M. D., 228 N. 5th street, Reading.
1883—Schreiner, Emma T., M. D., Cor. Wayne and Maplewood Aves., Germantown, Philadelphia.
1889—Schwenk, C. S., M. D., 1319 Jefferson street, Philadelphia.
1886—Seibert, W. A., M. D., 43 N. 4th street, Easton.
1900—Seibert, Walter W., M. D., Easton.
1868—SEIP, C. P., M. D., 636 Penn Ave., Pittsburg.
1889—Shallcross, I. G., M. D., 1631 Arch street, Philadelphia.
1879—SHANNON, S. F., M. D., 631 16th street, Denver, Col.
1883—Sharkey, W. P., M. D., 1938 Girard Ave., Philadelphia.
1885—Shellenberger, C. N., M. D., 1831 Wallace street, Philadelphia.
1892—Shoemaker, D. W., M. D., 1824 Green street, Philadelphia.
1900—Simmons, C. W., M. D., 1628 N. 18th street, Philadelphia.
1897—Simmons, S. S., M. D., Susquehanna.
1883—Slough, F. J., M. D., 845 Hamilton street, Allentown.
1892—Smedley, Charles D., M. D., Wayne.
1889—Smith, George W., M. D., 806 N. Broad street, Philadelphia.
1887—Smith, Mary E., M. D., 48 E. Diamond street, Allegheny.
1887—Snader, E. R., M. D., 140 N. 20th street, Philadelphia.
1900—Snyder, E. S., M. D., Lancaster.
1894—Somerville, W. H., M. D., 1214 Hanover street, Philadelphia.
1896—Spahr, Charles E., M. D., 10 W. Market street, York.

1889—Spencer, William, M. D., 1820 Chestnut street, Philadelphia.
1881—Stambach, H. L., M. D., 15 W. Victoria street, Santa Barbara, Cal.
1889—Starr, Pearl, M. D., 583 Lincoln Ave., Bellevue.
1894—Steele, William G., M. D., 1431 Girard Ave., Philadelphia.
1891—Stephens, W. R., M. D., Wilkinsburg.
1894—Stewart, G. W., M. D., 1728 Chestnut street, Philadelphia.
1885—Strong, J. Wilmer, M. D., 2049 N. 13th street, Philadelphia.
1889—Strong, Walter, M. D., 2049 N. 13th street, Philadelphia.
1896—Sureth, Theodore, M. D., Scranton.
1881—Thatcher, J. W., M. D., 35th and Hamilton streets, Phila.
1877—THOMAS, CHARLES MONROE, M. D., 1623 Arch street, Philadelphia.
1886—Thompson, J. H., M. D., 515 Penn Ave., Pittsburg.
1897—Thompson, J. J., M. D., Carbondale.
1887—Thompson, Landreth W., M. D., 1701 Green street, Phila.
1898—Thurston, Leon, M. D., Pittsburg.
1886—Tindall, Van R., M. D., 323 Reed street, Philadelphia.
1891—Tomlin, R. E., M. D., 2057 N. 8th street, Philadelphia.
1896—Tortat, Albin E., M. D., 3727 Ridge Ave., Philadelphia.
1896—Trites, Charles S., M. D., 4500 Baker street, Manayunk, Phila.
1896—Ulrich, Silvester, M. D., Middletown.
1881—Umstead, D. B., M. D., Tacony, 23d Ward, Philadelphia.
1883—Van Baun, W. W., M. D., 1402 Spruce street, Philadelphia.
1886—Van Deusen, Edwin H., M. D., 2105 Tioga street, Phila.
1896—Van Lennep, G. A., M. D., 1615 Chestnut street, Philadelphia.
1881—Van Lennep, W. B., M. D., 1421 Spruce street, Philadelphia.
1898—Van Tine, J. Lewis, M. D., 1613 Girard Ave., Philadelphia.
1889—Vischer, Carl V., M. D., 1429 Poplar street, Philadelphia.
1892—Waggoner, G. W., M. D., Corry.
1897—Walter, J. A., M. D., Punxsutawney.
1896—Walter, Robert, M. D., Walter's Park.
1894—Ward, J. D., M. D., 806 3d street, Philadelphia.
1894—Ware, H. B., M. D., Cor. Washington and Linden streets, Scranton.
1894—Wasserman, Flora E., M. D., 1909 N. Broad street, Phila.
1894—Waylan, Julia Gould, M. D., 1832 Tioga street, Philadelphia.
1881—Weaver, Chandler, M. D., Fox Chase, 23d Ward, Philadelphia.
1894—Weaver, H. S., M. D., 1621 Chestnut street, Philadelphia.
1883—Weaver, W. P., M. D., Bristol.
1894—Webster, Samuel C., M. D., Media.

1891—Wesner, M. A., M. D., Houtzdale.
1889—White, Roland T., M. D., 273 Western Ave., Allegheny.
1892—Wilbur, B. K., M. D., Sitka, Alaska.
1899—Wilford, H. H., M. D., Bangor.
1866—WILLARD, L. H., M. D., 236 Western Ave., Allegheny.
1870—WILLETS, WILLIAM, M. D., Williamsport.
1873—WILLIAMSON, M. S., M. D., 1311 Arch street, Phila.
1888—Yocum, C. A., M. D., 365 Chestnut street, Pottstown.
1880—Yoder, D., M. D., Catasauqua.
1896—Youngman, Maurice D., M. D., Atlantic City, N. J.
1894—Ziegenfus, A. Frank, M. D., 1124 Wallace street, Philadelphia.

HONORARY MEMBERS.

1883—Allen, H. C., M. D., 5401 Jefferson street, Hyde Park, Chicago, Ill.
1898—Custis, J. B. Gregg, M. D., 110 E. Capitol street, Washington, D. C.
1866—Doran, Charles R., M. D., Jacksonville, Fla.
1868—Helmuth, William Tod, M. D., 158 W. 59th street, New York.
1885—Houghton, Henry C., M. D., 12 W. 39th street, New York.
1876—Jones, S. A., M. D., Ann Arbor, Mich.
1900—Nash, E. B., M. D., New York.
1868—Paine, H. M., M. D., West Newton, Mass.
1883—Phillips, W. A., M. D., Cleveland, Ohio.
1898—Porter, Eugene H., M. D., 181 W. 73d street, New York.
1868—Rockwith, F. A., M. D., East Saginaw, Mich.
1892—Williamson, Alonzo P., M. D., Dayton Bldg., 602 Nicollet Ave., Minneapolis.

CORRESPONDING MEMBERS.

1873—Alvarez, Paz, M. D., Madrid, Spain.
1900—Burnett, J. C., M. D., London, England.
1873—Chauvet, Fernand, M. D., Tours, France.
1873—Eidherr, Francis, M. D., Vienna, Austria.
1883—Hughes, Richard, M. D., Brighton, England.
1873—Pope, Alfred C., M. D., London, England.

NECROLOGICAL LIST.

1866—Ashton, A. H., M. D., died February 18th, 1883.
1866—Barnaby, John E., M. D., died January 5th, 1869.
1867—Barrett, Charles B., M. D., died June 5th, 1871.
1882—Bernard, H., M. D., died ———
1866—Blakeley, W. James, M. D., died January 14th, 1877.
1870—Bratt, Benjamin R., M. D., died January 31st, 1872.
1895—Brierly, Frank Walter, M. D., died June 17th, 1899.
1866—Brooks, Silas S., M. D., died July 2d, 1871.
1883—Brown, Samuel, M. D., died March 22d, 1892.
1885—Buchman, Francis, M. D., died July 14th, 1898.
1883—Burr, Richard, M. D., died March 30th, 1885.
1873—Caruthers, R. E., M. D., died January 3d, 1885.
1868—Charlton, S. T., M. D., died November 9th, 1886.
1863—Childs, William R., M. D., died November 11th, 1888.
1866—Cook, William H., M. D., died March 11th, 1879.
1866—Cooper, John F., M. D., died August 19th, 1899.
1866—Cote, M., M. D., died May 29th, 1878.
1866—Cowley, David, M. D., died October 30th, 1886.
1868—Dake, J. P., M. D. (honorary), died October 28, 1894.
1866—Detweiler, Henry, M. D., died April 21st, 1887.
1886—Dowling, John W., M. D. (honorary), died January 14th, 1892.
1871—Dreibelbis, David L., M. D., died March 24th, 1872.
1870—Earhart, Jacob R., M. D., died June 23d, 1891.
1870—Farrington, E. A., M. D., died December 17th, 1885.
1880—Ferson, John L., M. D., died July 12th, 1896.
1866—Freise, Michael, M. D., died February 4th, 1880.
1866—Frost, J. H. P., M. D., died January 21st, 1875.
1889—Gangloff, Charles, M. D., died January 22d, 1898.
1866—Gardiner, Richard, M. D., died March 22d, 1877.
1866—Gause, O. B., M. D., died January 11th, 1895.
1886—Griffith, Jethro J., M. D., died July 5th, 1893.
1877—Grumbeid, William, M. D., died ———
1866—Guernsey, H. N., M. D., died June 27th, 1885.
1870—Guernsey, W. F., M. D., died February 16th, 1877.

1895—Hall, William D., M. D., died August 2d, 1897.
1888—Hawley, S. B., M. D., died March 6th, 1890.
1886—Herron, James A., M. D., died November 15th, 1868.
1866—Hofmann, Herman H., M. D., died April 4th, 1891.
1886—Holcombe, John Randolph, M. D., died December 17th, 1896.
1884—Hosfeld, George, M. D., died November 9th, 1884.
1873—Houard, J. G., M. D., died April 24th, 1878.
1882—Ivins, Horace F., M. D., died January 1st, 1899.
1866—James, David, M. D., died June 6th, 1873.
1866—Jeanes, Jacob, M. D., died December 18th, 1877.
1866—Koch, Augustus W., M. D., died May 4th, 1886.
1889—Lazear, Lyttleton L., M. D., died ———, 1898.
1866—Lee, J. K., M. D., died November 10th, 1887.
1869—Lee, John K., M. D., died May 31st, 1889.
1876—Lilienthal, S., M. D. (honorary), died October 3d, 1891.
1867—Lippe, Adolph, M. D., died January 23d, 1888.
1871—Lovejoy, E., M. D. (honorary), died August 15th, 1872.
1868—Malin, George W., M. D., died January 18th, 1883.
1886—Malin, John, M. D., died November 29th, 1889.
1866—Marsden, J. H., M. D., died August 27th, 1883.
1865—Martin, Henry Noah, M. D., died September 1st, 1889.
1881—May, Newton, M. D., died January 27th, 1889.
1866—McClatchey, R. J., M. D., died January 15th, 1883.
1870—Moore, Thomas, M. D., died March 25th, 1882.
1867—Morgan, John Coleman, M. D., died June 27th, 1899.
1873—Nichol, Thomas, M. D. (corresponding), died June 14th, 1890.
1869—Ostrander, W. M., M. D., died August 23d, 1881.
1868—Payne, Wm. E., M. D. (honorary), died March 9th, 1877.
1878—Pereira, Ignacio, M. D. (corresponding), died April 18th, 1881.
1868—Pfoutz, J. S., M. D., died ———
1866—Preston, Coates, M. D., died August 9th, 1881.
1868—Pulte, J. H., M. D. (honorary), died February 24th, 1884.
1882—Pursel, J. E., M. D., died March 15th, 1885.
1872—Rankin, John Stephen, M. D., died April 21st, 1899.
1866—Raue, Charles G., M. D., died August 21st, 1896.
1853—Reading, Edward, M. D., died March 7th, 1889.
1866—Reading, John R., M. D., died February 14th, 1866.
1870—Reinhold, H. E., M. D., died March 6th, 1879.
1871—Rittenhouse, S. R., M. D., died June 26, 1895.
1866—Roberts, R. Ross, M. D., died April 4th, 1875.

1887—Rodes, Joseph, M. D., died ———, 1898.
1866—Rosseau, L. M., M. D., died September 25th, 1882.
1872—Scott, James L., M. D., died August 15th, 1876.
1883—Skeels, James S., M. D., died ———, 1891.
1880—Smedley, Isaac G., M. D., died December 1st, 1899.
1870—Spencer, J. H., M. D., died ———
1872—Speth, W. F., M. D., died May 11th, 1881.
1889—Starr, Pearl, M. D., died July —, 1900.
———Stauffer, D. R., M. D., died March 16th 1874.
1867—Stevens, C. A., M. D., died January 17th, 1881.
1868—Talbot, I. Tisdale, M. D. (honorary), died July 2d, 1899.
1870—Taudte, F., M. D., died March 27th, 1878.
1871—Thomas, Amos R., M. D., died October 31st, 1895.
1891—Tindall, Harry Brooks, M. D., died January 9th, 1892.
1882—Trites, W. B., M. D., died January 19th, 1890.
1867—Walker, Manlon M., M. D., died March 31st, 1896.
1870—Waters, George H., M. D., died ———, 1892.
1880—Way, J. H., M. D., died September 3d, 1887.
1866—Williams, Thomas C., M. D., died October 1st, 1899.
1866—Williamson, Walter M., M. D., died December 19th, 1870.
1866—Williamson, Walter, M. D., died May 5th, 1874.
1848—Wood, James B., M. D., died April 14th, 1889.
1897—Yetter, A. F., M. D., died May 8th, 1898.
1874—Young, J. H., M. D., died June 21st, 1894.
1880—Zerns, Wm. M. M. D., died September 21st, 1887.

MEMBERS AND VISITORS PRESENT AT THE MEETING.

L. T. Ashcraft.
G. J. Berlinghoff.
A. P. Bowie.
D. F. Brewster.
C. W. Brickley.
J. A. Brooke.
S. H. Bruce.
J. A. Bullard.
Bukk G. Carleton.
S. A. Campbell.
Anna C. Clarke.
J. H. Closson.
Sara J. Coe.
J. W. Coolidge.
W. G. Dietz.
E. C. Dreher.
J. M. Drum.
T. S. Dunning.
I. B. Gilbert.
Ella D. Goff.
E. M. Gramm.
W. M. Griffith.
F. C. Haerer.
O. S. Haines.
F. E. Harpel.
W. C. Hartman.
J. W. Hassler.
H. F. Heilner.
A. C. Heritage.
P. P. Higgins.
E. H. Hill.
W. J. Holben.
John E. James.
T. M. Johnson.
C. W. Karsner.
D. S. Kistler.
D. C. Kline.
J. A. Kressly.
H. P. Leopold.
A. B. Lichtenwalner.
A. R. Mackenzie.
D. P. Maddux.
J. R. Mansfield.
E. W. Mercer.
R. P. Mercer.
Thos. Minahan.
Chas. Mohr.
Geo. B. Moreland.
Hon. F. M. Nichols.
H. L. Northrop.
O. H. Paxson.
Rev. Dr. Pearce.
J. L. Peck.
C. W. Perkins.
J. W. Pratt.
Trimble Pratt.
C. C. Rinehart.
C. W. Roberts.
W. F. Roth.
J. H. Sandel.
H. F. Schantz.
W. A. Seibert.
E. S. Snyder.
Theo. Sureth.
A. D. Thomas.
Thos. Thorburn.
R. E. Tomlin.
W. B. Van Lennep.
Julia G. Waylan.
W. A. Weaver.
F. A. Whitman.

PAPERS

AND

DISCUSSIONS.

REPORT OF THE

SECTION OF SANITARY SCIENCE.

Sanitary Science, by Trimble Pratt, M. D.
Hygiene of the Country School, by S. G. Godshall, M. D.
Advantages of American Climates and Health Resorts, by Bushrod W. James, M. D.
House Heating and Ventilation, by R. P. Mercer, M. D.
Ventilation of Dwellings, by C. S. Middleton, M. D.
Abuses in the Public School System as Causes of Ill Health, by Wm. C. Powell, M. D.
What Shall We Do With the Consumptive? by Henry L. Stambach, M. D.

SANITARY SCIENCE.

TRIMBLE PRATT, M. D., MEDIA.

In contrasting the work done by this Society in the domain of Sanitary Science with that of other subjects, I have thought it proper to take a cursory glance at the comparative importance of the relation which this subject bears to the welfare of humanity as compared with other branches of the health preserving art; and in so doing the fact is developed that this most important of all the subjects which claim our attention as physicians has received the least consideration at our hands, judging from the limited number of papers presented at our annual meetings and of the very few parts of the subject touched upon; hence the conclusion that there must be a lack of comprehension upon the part of the profession of the vastness, as well as the importance, of this field of investigation; to which in reality most other subjects are merely adjuncts.

During the last fifteen years the average has been about three papers annually, and several of these upon the same branch of the subject, consequently from such existing apathy, as well as admitted ignorance of the subject, if I may be pardoned, I will supplement this with a list of related subjects from which a selection may be made, especially by those who are deterred from joining us in our labors along this line through a lack of knowledge of the scope of

this field and which combine to make this department a broad and fruitful one for investigation.

The whole world and all its elements lie at our hands, only awaiting a painstaking scrutiny to furnish information which will not only serve to interest, but enable us to solve the mystery of the promotion of health in the most perfect manner, and to our fullest satisfaction; and to this end, then, let us glance at this fruitful field for subject matter for essays which, when treated intelligently and exhaustively, will surely add to the value and importance of these our annual meetings.

Go with me to the broad fields, to the hill tops, and into the valleys, by the rippling rill, and the rushing torrent; and here, while breathing the air of Heaven and warmed by the effulgent rays of the sun, let us note the effect of these upon human life, and by comparing the different sections of country and contrasting the effects upon the inhabitants, we will add greatly to our knowledge of these most essential elements of life and health.

Having considered these, the chief sustaining principles of life, we may turn our attention to the constructive powers which leads to an investigation of food products, which will be found to furnish an illimitable field of research, and so important when one considers how little attention is paid to a proper selection of the fuel which is intended to nourish and keep in motion the most wonderful engine in the world, the human body. In this realm will be found a myriad of subjects, through which may be thrown new light upon the mystery of life by comparing the different articles of food, as to their relative value as nutrients, as a whole, and also by an examination of their constituent elements under the head of general principles of diet, which might include:—

Quantity of food; energy obtainable from food; the relative value of food; digestibility of food, and the disease connected with food. Then, too, the different articles derived from both the animal and vegetable kingdoms would supply many valuable themes through which to still further increase our knowledge of the proper upbuilding of the body. Beverages and condiments will also supply many subjects of signal value bearing directly upon health and happiness; and before leaving the subject of Hygiene that of soil should not escape notice, from the very important part which it plays, under varied conditions, in the promotion of health and disease. In fine, Hygiene comprises the sum total of the preservation of health; by

securing the most perfect action of both body and mind during the longest possible period consistent with the laws of life.

For this reason, and from the apparent lack of interest manifested by the members of this Society in this all important subject, I have felt it incumbent upon me, in my feeble way, to urge upon each and every one the necessity of becoming more alive to a sense of the duty which we owe, not alone to the profession, but to ourselves and the public who are our patrons, and in a measure dependent upon us for a safeguarding interest in their welfare.

The labor of the physician, which is to a degree philanthropic, a labor of love, should be adorned with such devotion and humanitarian principles as would impel him to make such sacrifices of time, labor and ingenuity as should serve to garland his crown with immortality.

While it may seem both presumptuous and superfluous to thus urge upon you the necessity of becoming more willing and even enthusiastic workers, especially in this field, I hope I may be pardoned for entering a plea in extenuation, since it is obvious that one's conscientious devotion to duty constitutes the chief bulwark against the disqueting elements which are so abundantly strewn all along our pathway.

As eternal vigilance is the price of success, they who would desire the praises bestowed upon those who acquit themselves most nobly in the performance of the duties justly devolving upon them, and by which they may hope to become recipients of the plaudits of their fellows, must be willing to expend so much energy as will in the end bring to them the coveted reward.

To further set forth working capital for those who may engage with us in our labors for the welfare of mankind, and who may consent to render assistance in this important service, the following list of subjects, though very limited in number, may serve as hints:

The Adaptation of the Human System to External Temperature.

Adjustment of Dietetics to Different Circumstances of Health and Disease.

The Effect of Agriculture on Atmosphere and Climate.

Aliments and Alimentary Principles.

Animal and Vegetable Food Compared.

Animal Heat.

Bathing, Bed-clothing, Etc.

Mineral Waters and Their Application.

Chemistry of the Human Body.
Civilization; Its Sanitary Results.
Clothing, Hygienic Effects Of.
The Uses of the Cold Bath.
Condiments.
Dietetics; Importance of Study Of.
Dietetic Uses of Water.
Digestion; Dependant Functions.
Disease; Causes Of.
Drainage; Proper and Improper Effects Of.
Early Education.
Alcohol; Effects Of on the System.
Employment of Children.
Endemic and Epidemic Causes of Disease.
Muscular Expenditure Occasioned by Exercise.
Factories; Effect on Health.
Bathing of Infants.
Effect of Mental Exercise Upon Health.
Influence of the Mind on the Health.
Morbific Tendencies of Dyspepsia.
Development of Motor Powers.
Nervous Power Necessary to Digestion.
Effects of Muscular Exercise on Nutrition.
Effect of Different Occupations on the Health.
Importance of Public Pleasure Grounds.
Mutual Recreation of Mind and Body.
Effects of Seasons on Climate.
Effect of Sedentary Occupations.
Effects of Systematic Training.
Sanitary Effects of Travel.
Effects of Vegetation on Climate.
Ventilation; Natural and Artificial.
Character of Water for General Purposes.

HYGIENE OF THE COUNTRY SCHOOL.

S. G. GODSHALL, M. D., EDGE HILL.

I HOPE to call your attention today to some school methods that, although not new, are important, and are not given the consideration they deserve by our school boards.

But first allow me to say something in defense of the School Directors, that all these self-evident needs are not universal in our public schools:—

Remember that School Directors are *representatives,* and if the township is dominated by people of enlightenment their school board will probably take an advanced position in all matters pertaining to their duties; while, per contra: if the township is composed of ultra-conservatives, what was good enough for the last generation will likely be considered all that is necessary for the present needs, and, again, if in a township where schools have been kept as they were forty years ago a board of directors were to attempt to inaugurate all the modern hygienic needs at one time there would be so much objection made, that in all probability the future usefulness of that board would be greatly impaired. So you must investigate for yourself, when you hear of *your* board indulging in some streak of extravagance, and if you find they are but putting modern ideas into use, as is often the case, uphold them with your utmost power; or if your board is composed of a lot of Bourbons, who run the school with the sole idea of keeping the taxes at a minimum, try to get into that board yourself, or try to get some other physician into it to put some of the leaven of progress where it will do the most good.

We will divide our subject into

Care of health in general,
Care of individual health, and
Cleanliness.

Under the first head, Care of general health, comes light. Where there is but one room in a school, as is frequently the case in country districts, the light should come from the South or West and the pupils face West or North, as the case may be—here the blackboards should be on the side opposite the windows. If they are on the end

of the room where the child faces the side lights cause a glare that will ultimately affect any one's sight.

In other schools the light should always be arranged to come in over the child's left shoulder. This should be imperative, without regard to how it affects the school as an assembly room or interferes in any manner with the teacher's ideas of looks.

Heating with warmed or hot air is most desirable—one system in which large quantities of warmed (not hot) air is thrown into the room near the ceiling, while the ventilators are close to the floor, the used air being forced through a set of double joists, thus warming the floor after its usefulness is over for breathing purposes, comes near being ideal.

Next to this comes the ordinary hot air furnace, but here we need more attention given to ventilation than is usually the case.

The ventilation that is satisfactory, and that will come within the means of the small district school, is yet to be heard from. The ordinary steam heat, with direct radiation—that is—radiators in the room, should only be mentioned to be condemned. It is more unsanitary than the old stove in the room. The stove will not "draw" unless it gets oxygen, while the carbonic oxide laden air can (and often is) heated and reheated with the radiators, and coal is saved and health is ruined.

In old schools, or in schools built with no attention to ventilation, fair results can be had by opening all the doors and windows during recess, and thoroughly changing the impure breathed air for fresh cold air. The run that the children have had in their fifteen-minute romp will warm their blood so much that they will find the chilly, sweet air of the room grateful, and the heater will warm it sufficiently by the time their blood has begun to cool down to normal again. In this way we will have fewer "winter colds" than where the children come into an atmosphere at about 70° to 80° and the air charged with carbonic acid gas.

Teachers should understand hygiene enough to know that when the children get sleepy it is either because their brains are being overtaxed with work, or that the air they are breathing is bad, and it is usually the latter.

The water question has been so much discussed I will merely touch on it. In country districts the wells, whether the ordinary dug one or the drilled or artesian well, is almost the only source of this essential article, and about the only thing we can do is to try to keep

it from contamination. This is relatively easy if the surroundings are not much built up.

Associated with this question comes that of water-closets and urinals. In all cases, the cesspools should be walled up and tightly cemented, so as to be waterproof. The school laws call for their being cleaned every year, and with these precautions, watertight cesspools and frequent cleansing the danger of water infection from this cause should be at a minimum.

The school controllers have the right by law to take one acre of ground by condemnation if they cannot buy a considerable school site from obstinate owners. This, we think, should be a hint to directors to always get lots of at least an acre, never less. The need of ample playgrounds does not appeal to the rural authorities with as much force as it does to urban and suburban people; but every school, whether in a built-up section or at a country cross-roads, should have ground enough to grow, and ample to spare, for the boys' and girls' games that will give them the exercise needful to keep their blood red. In this connection allow us to say that we believe the time not very far distant when manual training and systematic gymnastics will be part of the curriculum of every public school. We hardly think that these most obvious aids to the children's development will always be monopolized by the city authorities. It will be but a short while before the country people will be demanding of their school officers that their children be no longer handicapped in the race for success by their urban competitors.

The Pennsylvania Legislature of 1898 passed a law allowing school boards to organize themselves as boards of health. The idea was to give them authority to try to control the spread of contagious diseases, the majority of such diseases being among children and the congregating at school being the usual mode of spreading. Quite a number of boards have availed themselves of this privilege and it should be accepted by all township boards, and then rigid rules made about the attendance of children in whose family an infectious disease exists, or has existed, at the same time adopting some modern sterilizing apparatus to disinfect houses in the district that have been infected and also to sterilize the school rooms during the prevalence of any epidemic; this should be done frequently for a two-fold reason—principally to check any spreading that might be possible by the school; and, secondarily, to give the people the confidence (that the source of danger is obliterated) so necessary to stay the excessive worry caused by a contagious disease in the neighborhood.

For the personal care of health we should have individual drinking cups and individual pens and pencils for the pupils.

Each school should have various sized single desks and the desk should fit the school—many rotary-lateral curvatures can be traced to the effort to make the child fit the desk. Many teachers seem to think that a certain aged child should occupy a certain sized desk, without regard to the child being over or under sized.

Another rule for the care of the individual should be that no child under any circumstances be detained at recess. The child's health demands that it have that quarter hour relaxation, and if the child is refractory and deserves punishment it had far better be with the old-fashioned switch than detention at any time.

Lastly, we have to deal with the spread of pediculi; this can be limited to a great extent by individual desks and seats, and also by boxes to hold cloaks and hats instead of the usual hook in the cloak-room.

DISCUSSION.

Dr. T. M. Johnson: In reference to the matter of ventilation of schools, as it comes under my observation as a physician, the children get sick and I am sent for. The child makes a very intelligent explanation of how it took cold in the school. The teacher opens the window, and so on. In our schools in West Pittston we have what are considered models of schools and school buildings, yet the system of ventilation does not always seem to be quite equalized with the heating, and it seems to me it is like this: The children go to school in a nice, fresh room and everybody gets down to work, and the teacher, with a large roomful of children, becomes engrossed in her work. Finally the air becomes heavy. She is not aware of the fact that it has become heavy and impure until she is roused up, and then the children are marched around for two or three minutes with the windows open. In the winter time this is done with the temperature at 20 or 30°. This little march is safe for some and yet not safe for others. I think our teachers should be impressed with the idea that if it is necessary to open windows the children should have sufficient exercise, so that all of them can have a free circulation of air, and so that anyone sitting down afterwards at a temperature of 20° less than the room was formerly could bear it. The teacher should have it on her mind that she should never allow her room to be surcharged, but constantly to have it ventilated. Soldiers are required to regain the line gradually, not with

a rush, and the temperature of the room should be lowered gradually, and not with a rush, so as not to subject the children to a great change suddenly.

Dr. Trimble Pratt: A good method of ventilating school rooms is to have ventilators and radiators at the floor, which I have seen very seldom adopted; that is, have a number put in under the lower sash; have two pipes that come in the window and turn up. These pipes have a damper in them, but there is always an inflow of cold air, not too great, but sufficient, and it is thrown up. When it circulates it does not strike anybody and it keeps fresh air in the school. This would obviate the opening of windows and doors and letting in a great volume of air at one time.

ADVANTAGES OF AMERICAN CLIMATES AND HEALTH RESORTS.

BY BUSHROD WASHINGTON JAMES, M. D., LL. D., PHILADELPHIA.

Every variety of climate that will in any way benefit an invalid can be found on this continent, and even in this country, so thorough and accurate are the descriptions of the various local climates in the different States and Territories indicative of this fact. The dictates of fashionable life, however, have taught the wealthier classes that a nomadic touring life among the fashionable and expensive hotels of the various resorts for summer and winter tourists are requisites for the preservation of their health or realization of the full enjoyments of life. The hotels are correspondingly fitted up with all the luxuries and supplied with all the dietary compounds and mixtures which a highly-paid chef can invent, regardless of beneficial or injurious effects, and served in such a way as to overload the digestive powers at almost every meal, even of those who are apparently in good health and who come to such resorts with the idea of maintaining their health under these adverse surroundings; while at some of these dominated health stations the influence is to the destruction rather than the maintainance of good health. This idea of crowding in upon fashionable resorts that have a wide reputation is far from what the climatologist or physician would suggest to his patient seeking an opinion upon the most beneficial climate for himself, the sufferer.

The places of resort among the mountain ranges of the Blue Hills, the Alleghenies, the Sierra Nevadas, as well as in other mountain chains, are well-known to the reader of works on climatology; and a consultation of the time tables of the various railroads will show anyone the easiest mode of access to the same; and the hotel accommodations may not be so expensive or so fashionable as are those along the seashores of the Atlantic and Pacific oceans, or in the older, more established and more widely-known spas or health stations of the Mediterranean or European mountain ranges, or the fashionable springs which abound in the lower levels of European countries, as well as our own.

Resorts higher up the mountain sides in this country carry with them as pure an atmosphere and as great a beneficial influence as do those in the Alps or other mountainous sections of eastern countries. The people living in the large cities east of the Mississippi mostly tend toward the climates of the seaboard summer and winter resorts, while those in towns west of the Mississippi have a natural tendency to drift towards the lovely summer as well as winter atmosphere of lower California and points further north on the Pacific slope.

Consumptives do better in an even, dry, sunny climate, where the variations of temperature during the twenty-four hours, and the temperature itself, is of such a mild character that they can be out a large portion of the day in sunshine and pure air.

The principal advantages of our climate, are:

1. The nearness and ease of access in comfortable trains to the most desirable resorts.

2. The ease of the return home in case of an increase of invalidism in the seeker after health.

3. The advantage of being among people of one's own tastes, language and habits.

4. The avoidance of the tedious, long-distance travel that resorts in Europe entail, as well as the sea-sickness and discomfort to which a very sick person on a crowded steamer is exposed.

5. In case of an aggravation of the symptoms and the invalid's desire to be among his or her friends or relatives the ease and rapidity of reaching their own home in a very short time.

6. The ease of communication with their climatic consultant or family physician, which should always be maintained, is secured in the home climate, whereas a long time must elapse, in case of any advice being required, should an invalid be in a foreign country.

7. We would expect that the patients of Homœopathic practitioners would necessarily desire, as they should, the advice and services

to be kept up by mail during the absence of the invalid from his or her home. For I have observed a practice, which is to be condemned, of local physicians creating an impression upon invalids who are sent by climatologists from the larger cities of the eastern part of this country, and who fall into the hands of medical practitioners in the locality to which they have been sent, and the unjust method of convincing one's patients that they must necessarily have a local physician as their home physician is not likely to understand the effects of the climate upon his patient. As soon as the patient ceases to seek the advice of his home attendant and falls into the hands of these money-making practitioners he is thereby experimenting upon himself and allowing a stranger to influence him contrary to the sound advice which his home physician would be as competent to give as anyone else, and even better from his general understanding of the temperament and special action upon the said temperament of the various remedies which he may have been in the habit of prescribing. Unless some serious complication should arise or sudden attack occur, no invalid should abandon the habit of frequent correspondence with the climatologist or home physician who has carefully recommended him to a special climate which he has studied out for the case. In case a change is needed the prejudiced local practitioner at the "resort" holds the case in his own hands as against the home physician.

8. Most invalids have to undergo a slight period of climatization to any new resort to which they may be recommended, and this change is much better borne by the invalid not going too far out of his native climate to a distant one, the peculiarities of which he may be unacquainted with.

9. By being in easy or ready communication with his climatic and medical adviser he can easily ascertain from him by a rapid correspondence whether a climate is beneficial or injurious, and before he is seriously injured he can have judicious advice returned him in a short time as to the next best climate to which he should resort and so maintain this previous advice until the proper location for his greatest benefit is obtained.

10. In case of the aggravation of the case the family and even the home physician can gain easy access to the afflicted one in time to be of comfort and relief in case a serious outcome should be imminent. Many advantages could be citied, but the above we regard as the principal features which would come in, in American climates for American residents, over more distant health stations.

HOUSE HEATING AND VENTILATION.

R. P. MERCER, M. D., CHESTER.

NOTWITHSTANDING the general diffusion of Scientific thought, an appeal to the rationality of man availeth but little unless it is made through the animal senses. To the thoughtful, danger may be scented from afar and deductions drawn from scientific facts. The few will detect the presence of disease and death in the air from an observation of its effect upon animal life, or from deductive reasoning upon its source of supply, supported by analytical experimentation. But to the multitude the air we breathe becomes impure only when it stinketh.

Strange it is, passing strange, that so little practical interest has been taken in the all important subject of House Ventilation. We, as physicians, realize the necessity of an abundant supply and constant circulation of pure air throughout the house; therefore that part of our subject need not be discussed here. But the laity do not, and unless we, as their advisors, become more enthusiastic and insist upon a change in the present methods we neglect an important duty, and might as well acknowledge ourselves failures upon sanitation.

Wonderful advance toward comfort and convenience, elegance and ease has been made in the construction of our modern homes. The water supply has received much attention; the sewer gas warded off; and the plumber's art well advanced towards perfection, under scientific direction and inspection. But when it comes to heating and ventilation, economy in fuel seems to have been the main object in view; and as a means to that end, to prevent the air from either getting into or out of the house.

Take the majority of our homes; the house with modern conveniences, new and tight, with steam plant, and direct radiation throughout, the confined air heated to eighty degrees or more, the oxygen almost exhausted, and the air charged with exhalations from the lungs until it will neither sustain life nor light.

That this is no exaggeration a case in point will show: I was at the bedside of a patient when one of those abominations, an oil-stove, was brought into the room to assist the lagging radiator; soon the

stove flickered out, it was trimmed and returned, and it burned low and was almost out, when I directed a window opened; the stove burned high; labor pains returned, and we were soon relieved all round; warmer, too.

Compare this with the abode of our colonial ancestors, with fire in huge open grates, carrying off great volumes of air up the chimneys to be replaced by a like quantity from without.

Compare the strong and ruddy inmates of the one with the weak and puny mortals of the other. It will need no expert to decide which is the culture field for pathological germs. Nor need we be surprised that such a fearful destruction is being wrought by tuberculosis and other zymotic disease.

If we follow the changes in the methods of heating down through the generations, from the open fire-place, with its huge back log and chimney, to the ten-plate stove, the "air-tight" gas burner, the hot-air furnace, to the steam boiler and radiator system of today, the advance is questioned indeed. Because with each so-called improvement an effort has been made to seal the houses and reheat the confined air.

The hot-air furnace appears to be about the only exception to the rule; and even it is more an appearance than a reality. The attempt is here made to force the air into the room that is already full. Two bodies to occupy the space at the same time; we all know what that means. The furnace does circulate the air, however; because, as a volume of hot air ascends one side of the flue, a like volume descends the other side, and is reheated to again ascend in turn; or an uncertain portion finds its way out through a chance crack or cranny, making room for so much fresh air to be supplied through the heater.

Although preferable to direct radiation from steam pipes, as at present constructed, it is unsatisfactory as a heater, and for ventilation a failure. The fundamental principle upon which a perfect system of ventilation and heating rests is so easily understood, so cheaply applied, and so satisfactory in its results, it is strange that it has been so generally neglected. It may be stated in a single sentence. *Afford a free and unobstructed channel for the escape of confined air.*

Around this the entire philosophy of ventilation centers. For more than a quarter of a century I have had such a system in practical operation in my own house with entire satisfaction. The details for its application are, a central stack consisting of three flues; one each for ventilation, smoke and hot air; the one for ventilation between the

other two that it may be kept warm, thereby causing a better draft for the cool, impure air to escape. This and the smoke flue are carried above the top of the house and open in one expansion together.

The hot-air flue is closed at the upper story. These flues all start from the cellar and are of liberal size. Into each room near the floor is a register opening into the hot-air flue, and alongside of it another of the same size into the ventilating flue. In the cellar, built in with brick, is one of Job Bartlett & Sons' wrought iron dog house furnaces. One of the best today, between the heater and the outer wall, is a cold air room, or chamber, six by twelve feet in size, carefully cemented on all sides to keep out the ground air; into this chamber the cold air is admitted from the outside, through windows at the side, and allowed to pass over a break to the rear of the furnace. In this way an abundance of fresh, pure air is always at hand, and puffs and currents entirely avoided.

No difference from which direction the wind blows, or how hard, we never notice it through the heater, nor does it make the least difference in its working. The hot air from the furnace ascends through the register, displaces an equal volume of used-up cool air through the ventilating register, and a constant, although imperceptible, circulation is kept up throughout the house because all the inner doors and all registers are left open. Several years ago I added to this furnace a hot-water system, consisting of a copper coil suspended from the inside of the "dog house," immediately over the fire box. From this coil pipes are carried to the halls and exposed places, through which a constant circulation of hot water is kept up. This is a great aid to heating, without disturbing the volumes of air displaced, or any additional cost for fuel.

The Chester High School adopted this system several years ago; and the T. Lewis Crozer Home for Incurables has it in successful operation, erected by the Philadelphia Steam Heating Company. And in many of our public institutions it is giving general satisfaction.

It is the private dwelling, our homes, that are so almost entirely neglected, and that need our attention.

I have no desire to contest the germ theory of phthisis pulmonalis, or to question its infectious character; but I do contend, and most emphatically insist, that if we would adopt a system of ventilation and heating founded upon the principle here stated, and see that it was put into practical operation under competent inspection, as is our plumbing, there would be but little need to quarantine the consumptive, as the Secretary of our State Board of Health insists should

be done; because the mortality from consumption would not only be greatly lessened, but the victims to it would be reduced to a minimum.

In our enthusiasm after germs we sometimes appear to lose our rationality and chase an effect for a cause.

DISCUSSION.

Dr. T. M. Johnson: I cannot agree with the paper throughout and feel like coming to the rescue of our architects in this part of the country. As far as I am able to learn how they are building their houses, ventilation is very well taken care of, and the people through this section of the country seem to have an idea that ventilation is a necessity. Of course, there are exceptional cases, like the one spoken of, but in the houses we see built now I think the ventilation is looked after, both where steam heat and hot-water heat are used. People have always regarded the house, chimney, cellar and top, and there should be a constant circulation everywhere. I do not believe in closing up the cellar, putting a ventilating box from the outside window to your furnace. I believe in keeping a nice, clean cellar and letting your air come through. Use a furnace, keep your cellar clean and sweet and then let your air come up, and let the heat act upon this cold air, which will give you sterile hot air and plenty of ventilation.

VENTILATION OF DWELLINGS.

BY C. S. MIDDLETON, M. D., PHILADELPHIA.

The ventilation of dwellings is so intimately associated with the heating of them that it is impossible to speak of the one without taking into consideration the other: it is, indeed, the faulty heating of our dwellings that makes, in a great measure, the greater necessity for perfect ventilation; therefore, it shall be the aim of this short paper to call attention to the many wretched apologies for heaters and ranges supplied to many of the dwellings in the large cities and towns of the entire country.

With the advent of coal as a fuel within the last half century, it seems astonishing that so little attention has been given to the exhalations of gas from the heating apparatus placed in the dwelling. Very little attention seems to have been bestowed upon the ventilation of dwellings, but some effort has been made to place large halls and

churches upon a plane of properly ventilated (temporary) dwellings, but with what only partial success is most emphatically demonstrated when we remember how often one is either placed in an unbearable draft or the air within which we are compelled to breathe becomes both disgusting and positively dangerous to health.

There are, perhaps, two reasons which enter largely into the cause of imperfect ventilation of dwellings—firstly, the expense attached to the requirements for the (particularly) cheaper class of dwellings and consequent indifference of the builders and owners, and secondly, the need of a really perfect system for accomplishing the desired result.

It is plain to every one that to ventilate our rooms it is necessary to drive out vitiated, used-up, or contaminated air, and to replace it with pure air from without. How is this to be done without opening windows or doors? thus creating draft, and too suddenly changing the atmosphere in the room. The only safe way to keep the air in the room pure and healthful as possible is by a constant interchange of atmosphere from without in a gradual manner under constant regulation, and by giving the heated air, which has already done the service required of it, and which has at the same time become more or less laden with impurities, a chance to escape.

To introduce a system of ventilation for our living rooms it is necessary to begin with the construction of the dwelling by constructing flues in the chimney besides that for the draft from the heater or range—one for the escape of the heated air and one for the in-take of atmosphere from without—the one opening into the room near the ceiling and the other near the floor, protected by a revolving blind for adjustment as may be required.

In large rooms it would even be better to have ventilating flues opening into the room on opposite sides.

There are two strata of air in a heated room in which a number of persons are congregated, both more or less impure—the top or heated stratum—and that near the floor, the latter contaminated by carbonic acid gas from the exhalations of the lungs, this gas being heavier than the atmosphere, while, if there be an escape of gas from the heating or cooking appliances, an additional danger to health is commingled; this sulphurous acid gas being somewhat lighter than the former is distributed more uniformly. When it is realized that a man on an average—according to weight—gives off in twenty-four hours from 12 to 16 cubic feet or more of carbonic acid gas from the lungs—besides an undetermined quantity from the skin—not less

than 0.6 to 0.7 cubic feet per hour, the necessity for ventilating all rooms, but especially those in which a number are congregated, becomes very apparent.

It was the want of ventilation that has caused the death of numbers who have been crowded into prison cells and the holds of ships on more than one occasion. The same is true, of course, where persons have inhaled the fumes emanating from stoves, ranges, etc., where there is no chance for the escape of the gas, nor the incoming of fresh air. There would be less illness in families if it were possible to introduce into densely populated rooms the required 3,500 cubic feet of fresh air per head during the twenty-four hours.

The question of ventilation of sleeping rooms has often been a subject of discussion; this part of the subject may be dismissed by quoting from an eminent authority, in which he says that "It is as safe to sleep in a wholesome air as to be awake in it." Therefore, we should see that the sleeping room is as thoroughly ventilated as is the living room.

The necessity for more than the natural sources of ventilation is more apparent in city houses than those in the country, where situated as the latter are, isolated, every opportunity for natural ventilation exists. As the interchange of the air in the room depends so largely upon the atmosphere supplied to the heating apparatus it becomes an important matter from whence the supply is furnished. As it is known that the purer air in large cities is situated from 6 to 40 feet above the ground, it becomes apparent to all that in scarcely any instance do we get the best that we should have, but sometimes the best obtainable, when the in-take is elevated above the pavement as far as practicable, and very often the *worst* is used, when the cold air draft is sucked in from the lowest point, the window cellar, and worse still, from the floor of the cellar, and *worst* of all, to be loaded with sulphurous acid gas from imperfectly fitting or perforated drums or cast iron air chambers imperfectly fitted.

Ranges are frequently made to do the duty of both heating and of cooking; this should never be allowed, as there is always both imperfect heating and an escape of gas.

It follows then that the more nearly perfect the heating apparatus the better the ventilation.

Of the two systems of heating, direct and indirect, it would seem the indirect should be considered the better, and for this reason: Taking it for granted that steam, or hot water, is the best medium, the heating radiator can be placed in the cellar in a trough built express-

ly for it, into which the outside air is brought, and passing over the radiator on up into the room, thus giving both the desired heat and, if the air be pure, a fresh supply of atmospheric, although a drier, air, and if the facility for proper interchange of air is present a proper ventilation will take place. The objection to direct radiation from whatever source it may be derived is that the important feature of the two factors—heating and ventilation—the latter is likely to be neglected, and the vitiated air remaining in the room becomes heated without the imperative requirement being fulfilled of introducing the supply of fresh air from without.

To sum up:—To secure the best form of ventilation, the heating apparatus should be by the indirect system, taking the air from without; to facilitate the ingress of fresh air, the rooms should be equipped with proper ventilating flues built in the chimney, and if the rooms be very large it would be better still to have either pipes or flues built in the walls in front, or where the house has outside walls put them there as well, thus facilitating both systems of artificial ventilation—pulsion, and aspiration. It should be the duty of the physician to always be on the alert in detecting impurities in the rooms to which he may be called, and to do his best to have them removed.

Lastly, it is just as necessary to have an inspector of heating and ventilation as it is to have some one to look after the construction of the building, and we should take some means to have such an one employed by city and town governments.

ABUSES IN THE PUBLIC SCHOOL SYSTEM AS CAUSES OF ILL HEALTH.

WM. C. POWELL, M. D., BRYN MAWR.

Ill health among public school children is due in many instances to *overcrowding* of school studies; in fact, many children are so worked they have no child life; they are being driven at too high pressure, thinking of their studies and examinations when they should be relaxing on the playground; their playtime should be now, while in fact their school seems never out. In the fields the butterfly and tree-toad are turned into object lessons; even insects are torn to pieces in order to be instructive. When school is out the child should be gay and free. Oh, for the good times when school hours, only, was

the time for study, and in playtime there was no thought of anything but play. Go into any public school and you will see boys with flat chests, girls with waxen skins, pallid as day-lilies, giving them that peculiar school complexion with which we are all familiar. Every incentive and stimulus is held out; dread of censure, love of praise, foolish ambition of parents and teachers to have those under their care excel. Look at the long lines filing past, each pupil carrying three or four books to be studied at home, in hot rooms and by sight-destroying lights, demanding the use of glasses to help eyes worn prematurely old by night work. Many school rooms are nothing more nor less than hot-beds for eye troubles. Statistics show the three higher grades in our grammar schools suffer most in this particular. As a remedy, would suggest that eyes of all children should be tested before admission as pupils to the schools, and if they prove much below normal parents should be advised to seek professional counsel, and they should not be permitted to resume study until certificate to that effect be presented. The object of true education is to find the bent and quality of each pupil's mind and give only such food as will develop them. Just here is the source from which many evils of education arise. What then is wrong? Too much education? No! No one with average intelligence can doubt that to educate one, or so develop his or her individual capacity and fit him or her for their especial place in life, is the best thing we can do, but it must be done with wisdom and discrimination. In our public schools I fear oftentimes little judgment is shown. We cultivate human souls "en masse." In our schools today are boys and girls with many differing capacities, tendencies and destinies, and each is being crammed with the same dose of unassimilable facts, which is cruel and ridiculous in the extreme. It is the same old story of the boys of Dotheboy's Hall, who were ranged into a row while Mrs. Squeers ladeled into each gaping mouth the same dose of treacle and sulphur. May we, as physicians, appreciate and urge upon instructors the fact that "there is no blessing like the education which can be used, but that which cannot be used is a curse."

DISCUSSION.

Dr. Anna C. Clarke: I have been very much interested in the subject of the old problem of the work in the public schools. It does not seem to be "how well," but "how much" is learned. I know our public schools in Scranton have a curriculum—this is in the grammar grade—of ten recitations each day. In trying to do that the scholars

are given fifteen minutes to learn their spelling lesson and get out of the building at noon. They are given thirty minutes for drawing. I am intimately acquainted with a number of the principals of the grammar schools, and it is their continuous complaint that they cannot do justice to these subjects. It is not a matter of the teachers being willing or anxious to crowd students. It is due to the ambitious publishing houses. They get hold of the board of directors and get their systems in and find places for them. I doubt very much if any student can do justice to more than four subjects during a day. That would give them time to prepare their lessons in school and that would give them time to be thorough in what they learn. Then, too, as far as health is concerned, say, in public schools, especially in our towns and large places, I believe ill-health often comes from doing two things at once—attending school and attending society functions. They begin down in the intermediate grade to have progressive euchre parties in the evening. A child cannot be up until 11 or 12 o'clock at night and do any kind of work at school. One of the principals of our schools said it came from street-walking. He found the children out doors after 9 o'clock in the evening so frequently that he claimed that attention to society functions and not too much study was the cause of their ill-health.

I think, as physicians, we have a duty to urge parents to let children do one thing at a time. If they wish their children to go into society, let them go there, but take them out of school. If they want, however, to have an education, let them go to school and spend their strength in this direction.

Dr. A. P. Bowie: I can endorse all that has been said. I think the multiplicity of studies in our schools is a great mistake. The rudiments and elements of knowledge are lost sight of and they try to get a complete education in a shorter time. In the old catalogues of medical colleges, and when I attended lectures, there were seven chairs. If you get hold of a medical college catalogue now you can hardly count the number of professors they have. There is professor of this and professor of that, and all branches of knowledge. I think the medical schools are getting to be the same that the public schools are now. I think a child sent to school should not be overburdened with a multiplicity of studies. I think it is the great trouble we have to contend with nowadays. They should learn to spell, read and write, and they ought to have a knowledge of arithmetic. The three r's should have their place, and they should learn them thoroughly and well. After they get out of school there are some things to be

learned, as well as in school; there is no use of trying to get all the knowledge in school. The same way with the doctor; he learns a great many things after he leaves the medical college that he could not learn in the medical college.

WHAT SHALL WE DO WITH THE CONSUMPTIVE?

HENRY LAING STAMBACH, M. D., SANTA BARBARA, CAL.

THIS has become a most pertinent question to us of the Pacific Coast, and perhaps nowhere a more serious one than in Southern California.

It is no longer of importance alone to the invalid seeking to regain health, but vastly more to the multitudes, who, taught by the bacteriological discussions of the medical and lay press, are taking alarm at the incursions of numbers of serious invalids, who, to prolong life, or make declining days more endurable, hesitate at nothing for comfort's sake, entirely oblivious of the rights of others in the premises; so ill-informed are most and so absolutely selfish are all such sufferers that from the old-time commiseration a considerable revulsion of feeling is noticeable, and the *well* individual must needs look to it that he and his family and belongings are not destroyed by this menace to civilization. In consequence this peculiar sufferer has become "persona non grata" in many hotels, boarding-houses, and even to owners of rentable properties.

State quarantine has been broached only to be held in abeyance, public opinion remaining merciful, even though against self-interest.

It must be understood that California possesses many varied phases of climate, altitude, fertility, and opportunity for livelihood, and from all other quarters of the country *well* people come to enjoy this land of sunshine and flowers. The weary and heavy laden find it a veritable "land of the lotus." For extreme youth and age it is a garden of Eden. Here normal life is fostered and prolonged. Existence is made enjoyable until this specter of disease, with its horror of infection, brings dismay.

Our country is yet too new to offer in sufficient number special sanatoriums to accommodate all the visiting tubercular patients, and if they were available relatively few would accept their proffered shelter. But that soon such resorts must be the goal for all advanced cases is simply a matter of common justice.

If the limits of a short paper were to be of avail, it might be suggested with some insistence that eastern physicians advise all rapidly advancing cases to remain East to enjoy home, friends and familiar comforts, for be assured that such patients, finding themselves thousands of miles removed from all they hold dear, suffer as greatly from "home-sickness" as they do from their disease.

A patient willing and able to adopt an out-of-door life, with strength and means to warrant the undertaking, possessed of will-force and courage, may accomplish much by change of climate.

Especially is this true if but an incipient or hæmorrhagic case, but even he should be directed to secure the advice of a local practitioner as to habitation, clothing, exercise, food, rest and treatment, as it is incredible to what degrees of recklessness many otherwise favorable cases will indulge caprice to their utter undoing.

The patient should be advised regarding what might with propriety be termed the ethics of the invalid, and some hint be given of his duty to his fellow, as lamentable lack of information forms the base of much unhappiness and often renders him liable to unavoidable discourtesy. It is a delicate matter to warn a stranger, who otherwise would share our sympathy, that he or she is a menace to life, yet all social grades vie with each other in violating the "Golden Rule" and cannot be made to understand themselves as undesirable residents when disregarding street ordinances against expectoration, and this to such an extent that every breeze conveys to the apprehensive elements of infection, to say nothing of direct contamination of domestic stock intended for food.

While undoubted instances of almost miraculous climatic cure are of record, yet it may be safely affirmed that all bridges must be burned when coming West for health. A rare exception may possibly exist, but this rule is practically absolute. Upon him, to whom new lease of life is given, it is incumbent to remain and conserve his forces. He may in return for "length of days" assist in developing the country, and that, too, not without pleasure and profit.

The particular phase of suitable climate must in the main be discovered by the individual patient. San Antonio, Phoenix and numberless towns in Southern California afford a wide range of choice, and if well discussed in advance few radical errors will be made.

Occasional change is admissible, but as a rule letting "well enough alone" will prove a safe guide. Until established in health wide explorations should be avoided. Stimulation here should be shunned. Generous fare, rest and the homœopathic remedy when indicated

will give good results whenever within the range of possibility.

The notable collapse of all fads of treatment from the Bergeon method to antiseptic inhalations should inspire us with renewed zeal in apply the Law of Similars in its purity as continued experience but broadens our ability to serve our people and increase our admiration for the founder of homœopathy.

DISCUSSION.

Dr. A. P. Bowie: The question at the head of this article, "Where Shall We Send Our Consumptives?" is a very important question. My answer would be not to send them away at all, but to keep them at home. But another question arises, Are we to expose other persons to the painful effects of this disease? Now, for my part and from my experience, I have never seen a case of consumption communicated from one person to another, notwithstanding the writings and experience of others on that subject. Like the leper of old, the consumptive today stands as a menace to all who come near him, according to some persons, but I do not believe that at all. I believe that a consumptive can be treated at his home, and that he can be waited upon by well people and can be attended to by them without running any risk of them taking the disease. I think it is a shame, and a most unkind way of treating this class of patients, to make them believe that they are going to give this disease to somebody else. I have had experience with all kinds of cases of consumptives in all kinds of families, and I have never seen one case communicate that disease to the others. And as to sending them away, I think it is a risk, and I do not know of any place where there is an ideal climate. Where there is a man, woman or child with this disease surround them with all the comforts of home, give the proper homœopathic remedy, and you will get better results than by sending them on a long journey to a distant clime.

Dr. W. J. Martin: Notwithstanding what our friend has said, I believe that if I, before the time of the next meeting, was pronounced by one of our diagnosticians as having every evidence of going into pulmonary phthisis, I would not stay in Pittsburg.

REPORT OF THE

SECTION OF CLINICAL MEDICINE

The Clinical Value of Serum Therapy Applied to the Treatment of Diphtheria, by A. B. Lichtenwalner, M. D.

The Clinical Aspect of Sore Eyes, by C. H. Brown, M. D.

Diphtheria, by I. B. Gilbert, M. D.

Normal Development of Infancy, by W. M. Griffith, M. D.

Discussion of Gastric Ulceration and Its Treatment, by Oliver S. Haines, M. D.

What Would Hahnemann Do If He Was Here? by O. H. Paxson, M. D.

The Prevention of Pulmonary Tuberculosis, by E. R. Snader, M. D.

Cancer of the Alimentary Tract, by R. E. Tomlin, M. D.

THE CLINICAL VALUE OF SERUM-THERAPY, APPLIED TO THE TREATMENT OF DIPHTHERIA.

ABBOTT B. LICHTENWALNER, A. M., M. D., PHILADELPHIA.

Undertaking the duty to which you have assigned me, my first embarrassment was to find a proper subject. The purpose of our gathering is mutual assistance. The treatment of disease is more than ever definite in character, and this is due to a better knowledge of Physiology and Pathology, while drug-action must be thoroughly understood and the administration of drugs be based upon such knowledge. To those who realize the many radical changes that have taken place in the healing art during the closing years of this century, it is not too much to say that a New Era has begun, one in which the rational treatment of disease engages the best thought of the best workers.

Let me quote some actual observations concerning the use of Serum-Therapy in Diphtheria, which I trust will add to our medical knowledge. Perhaps you may remember that I presented my results in the use of Serum-Therapy as a specific for Diphtheria to the State Society at Pittsburg in 1898. See Transactions, page 174. This

product has since been so largely employed, and its effect so carefully and persistently studied, that in all the materia medica today we have no remedy whose value is more widely known and which is more extensively employed.

The discovery of Diphtheria Anti-toxine was made step by step, one investigator basing his researches largely upon the findings of another, and since then many scientific men have contributed their researches.

Let me quote the eloquent words of Hon. John Griggs, at the dedication of Hahnemann's Monument, in Washington, D. C. He said: "Hahnemann exposed fallacy, found truth and showed things not as they were believed to be, but as they are. It is not his chief glory that he founded the Homœopathic School, but that he uncovered errors and disclosed secrets of Nature, which all the world has recognized as correct without regard to School. He accepted no dogmatic assertion of Philosophy, nor any arbitrary council where the secrets of Science were concerned. The kingdom of Heaven, it may be, cometh not by observation, but that is true of no other thing. Hahnemann, like tens of thousands of investigators of the present day, believed that the truth would be recognized and found by experiment and observation, and in enunciating that belief he met with opposition and persecution. It is not in Jerusalem alone that the Prophets are stoned, and so this man for the truth's sake endured persecution."

And so with the Anti-toxine treatment, it was born and reared in a laboratory, and is the child of no school. It will save millions of cells from destruction, but it will not revive a single one. The theory of preventive inoculation, until recently the fundamental law of Anti-toxine and Serum-Therapy, was thoroughly worked out for Anthrax and Erysipelas by Pasteur, in 1880, and the first experiment upon diphtheritic patients was undertaken in the year 1893.

The germs employed are taken from the membrane of a diphtheria patient, the most virulent cases being selected. Toxine is grown by sowing the germs from pure cultures in sterilized beef broth, or bouillon, and exposing them in incubators for two or three weeks. During this period millions of bacilli develop and cover the broth with a friable scum, saturating it with their peculiar Toxine. Certain germs always produce a specially strong Toxine, and these are the most valuable in a laboratory. When the Toxine has been grown a germicide is added, and the dead germ subsequently removed by filtering through earth or unglazed porcelain. The living germs float upon the surface, while the dead fall to the bottom in a chalky de-

posit. Only Toxine, with all the germs removed, is employed in treating the horse that is to yield Anti-toxine.

The clinical course and symptoms of Diphtheria are, first: The period of incubation, and the prodromes of Diptheria are not materially unlike those of any other infected disease, except in degree. Rarely there is a decided chill; always some chilliness, followed by slight headache, febrile excitement and general malaise, with occasional vomiting. In mild cases this first stage is always insignificant, and even in some severe cases may attract but little attention, so that the onset of Diphtheria generally seems abrupt and it frequently happens that some difficulty in deglutition first leads the physician to explore the fauces and find there the characteristic membrane. Again when your attention is first attracted you may notice the characteristic muffled voice and the familiar swollen glands. The membrane is separate and distinct from the mucous membrane upon which the infecting bacillus has planted itself, although it may dip down quite deeply and be firmly adherent. This is considered characteristic of true Diphtheria, and when detached you have some bleeding from the underlying surface. Then cases vary greatly in extent, consistency, color, tendency to spread, and in the inclination of the membrane to return when removed. The membrane may cover but a small extent or become so general that it fills the pharynx great vault posterior nares, or the nares, and causes much suffering by mechanical obstruction.

Diphtheritic membrane is very dense, almost horny, having the consistency of soft leather. In color it is a grayish white, and the rapidity of formation, the proneness to spread from the pharynx into the larynx, or into the nares, and the readiness with which it is reformed when detached, are the most striking of all its characteristics. As a result of adequate Anti-toxine treatment, early applied, the retraction from the periphery gives rise soon to a characteristic red line, dividing the membrane from the areola of inflammation. This has been termed the "red line of demarkation." With this line once formed the membrane seldom oversteps it.

The symptoms of Diphtheria present a variable picture. In the Pharyngeal type the picture in the main is characteristically destructive, but in Laryngeal Diphtheria it is always that of Laryngitis. In either type the picture may vary as to severity; it ranges from the mildest sore throat to the most malignant form. The extent and severity of the local condition can never be employed as a criterion of the severity of the constitutional invasion. However, other things

being equal, the more extensive the membrane the larger the quantity of Toxine produced, and consequently the more absorbed. It is, however, not essential to even the highest degree of Toxæmia that the membrane be extensive, although the sole cause of fatality in Diphtheria is Toxæmia and its far-reaching and cell-destroying effect.

Diphtheria is self-limited, tending toward a fatal issue in typical cases. Malignant cases frequently terminate in three or four days, if not interrupted by death. Convalescence adds from three to six weeks to the course of the disease.

Next the variations, termination and complication. A case may be so mild as to be mistaken for most ordinary sore throat, the membrane significant, the constitution free from invasion and febrile action practically absent. The membrane then does not reform when dislodged and leaves a patch of mucosa abraded and reddened. Its course is run in about one week and the patient, though pale and debilitated, convalesces rapidly. Again a case may develop the most profound systemic intoxication very early and yet show but little membrane. It may be possible to cover the patch with the end of a pencil, yet the entire system may be saturated with Toxine. The system in such cases becomes irretrievably invaded. The cells are unable to produce sufficient Anti-toxine, and death is the result. Such cases have a frightful mortality, for the reason that the short and sharp course which they run affords a meagre opportunity for early inauguration of the proper treatment. Then, again, the formation of membrane may be so exuberant as to be mechanically a source of danger, for the membrane spreads with the greatest rapidity, and if dislodged speedily reforms. Constitutional symptoms may indicate only an ordinary invasion systematically, if the local conditions may rise in such prominence that the patient is in imminent danger of asphyxia. If the membrane is not disturbed, layer is superimposed upon layer, the case lasting from two to five weeks, and the secretions from this abundance of pseudo-membrane gives opportunity for auto-infection. This accounts for the tendency of the membrane to spread downward into the larynx, trachea, bronchi or into the naso-pharynx, nares, to the lips or into the Eustachian tube.

Sometimes an infection which begins slowly suddenly acquires great activity and assumes malignancy. Exceptional cases will show evidence of approaching convalescence two or three times, only to be reinfected, or more frequently to be followed by one of the eruptive fevers. These are the cases of so-called Chronic Diphtheria. The

complications are both local and constitutional, sloughing, hæmorrhage of the nose or throat, extension of the membrane into the Eustachian tube, or into the middle ear, and paralysis of the muscles of deglutition, albuminuria, subcutaneous connective tissue hæmorrhages, dermal eruptions and general paralysis. The glands contiguous to the local lesion, the sub-maxillary, parotid, etc., are always markedly swollen, early. Albuminuria is present in all severe and in many apparent mild cases. Pericarditis and Endocarditis are rare. Myocarditis is a common and frequently fatal complication, and is present to some degree in all Toxic cases. Invariably the stomach is functionally deranged and septic infection is the most frequent complication here, when the case has not been treated early. Thrombosis and Embolism affecting the vessels of the heart and cerebrum may cause Hemiplegia, Aphasia, Eclampsia, or even sudden death as a sequel. Scarlet Fever complicates Diphtheria less frequently than Measles, but it is more frequently the cause of a fatal issue.

Convalescence from Diphtheria is always slow and irregular and frequently treacherous and disappointing, especially in the hypertoxic cases. Post-Diphtheritic paralysis results from peripheral neuritis, caused by the direct action of Diphtheria Toxine upon the nervous structures, and under Anti-toxine treatment the proportion of cases developing paralysis is decreased in the same degree as the proportion of recoveries is increased.

With the introduction of Serum-Therapy in the treatment of Diphtheria has come an increasing demand for more minute discrimination and earlier conclusions in the diagnosis of this affection. The assurance that in Diphtheria Anti-toxine we possess an antidote to Diphtheria and a successful preventive of the proliferation of the Krebs-Loeffler bacillus is sufficient reason for the demand for the earliest possible satisfactory diagnosis and the importance of minute discrimination. If the examination shows the presence of Diphtheria bacilli, and the affection remains practically unchanged, give the patient the benefit of the doubt and administer one-thousand units of Anti-toxine. The doses of Anti-toxine have been well worked out clinically. Immunizing doses range from 200 to 500 Anti-toxine units and depend upon the age and degree of exposure. The curative dose of Anti-toxine ranges from one to six-thousand units depending upon, first, the age of the patient; second, the site of the local lesion; third, the extent of the pseudo-membrane, and fourth, the degree of Toxæmia present. There is no known maximum limit in dosage, except in the quantity of Serum necessary to inject. Chil-

dren really require larger doses than adults and younger children more so than older ones. Their tender age renders them peculiarly susceptible to the specific action of Diphtheria Toxine.

However, in conclusion, the fact that many medical men eminent in their respective branches still disclaim the Serum treatment, I am happy to say that their evidence is certainly inadequate to offset the large volume of evidence in its favor.

THE CLINICAL ASPECT OF SORE EYES.

C. H. BROWN, M. D., PHILADELPHIA.

THAT omniscient and omnipresent creature, the family physician, is supposed to understand the human body, from the crown of the head to the sole of the foot, and to be able to treat every disease to which it is subject, from A to izzard. But this statement is not as generally true today as it was thirty-five years ago. We are told that this is an age of specialism, and the prediction has been made that it is only a question of time when the genus family physician will become an extinct animal, and each organ of the body will call for a separate physician to treat its own particular ailments. To counteract this tendency some of the medical journals are advising their readers not to divide up their patients among the various specialists, but to study neurology, gynæcology, ophthalmology and all other ologies, and thus retain their patients and their dollars.

It is not my purpose to argue the need of specialism, nor to discuss the relations that should exist between the physician and the specialist, but I wish simply to mention a natural division of Diseases of the Eye into those which can be treated by the general practitioner and those which are beyond his province, and I propose to consume but a few moments of your time in doing so.

There are four grand divisions of Diseases of the Eye, as follows:

1.—Errors of Refraction.
2.—Operative Diseases.
3.—Deep-Seated Inflammations.
4.—Superficial Inflammations.

And in a general way we may say that the first three divisions are beyond the limits of general practice.

1. Optometry is the science of measuring the refractive condition of the eye and of detecting and correcting the various Anomalies of

its Muscles. This requires a knowledge of physics, of optics, of mathematics, of light, of lenses, etc., calls for technical skill, and necessitates an outfit of Trial Lenses, Ophthalmoscope, Retinoscope, Perimeter, Ophthalmometer, and other instruments, as well as special conveniences for testing. The physician is therefore scarcely prepared to treat this class of eye diseases.

2. Operative Diseases.

The Diseases of the Eye that call for operation are Cataract, Strabismus, Glaucoma, Conical Cornea, Staphyloma, Pterygium, Stricture of the Lachrymal duct, Serious Injury or Inflammation calling for Enucleation, and some others. It goes without saying that the physician is neither prepared nor inclined to undertake this class of diseases.

3. Deep-Seated Inflammations.

The eye is prone to a number of deep-seated diseases that are not only accompanied by all the symptoms of inflammation, but seriously threaten the usefulness of the organ, and often end in destruction of vision. Among these may be mentioned Iritis, Scleritis, Posterior Staphyloma, Choroiditis, Cyclitis, Hyalitis, Retinitis, Detachment of Retina, Neutritis, Optic Nerve Atrophy, Amblyopia, Glaucoma, etc. The diagnosis and treatment of these diseases calls for such skill as is only possessed by a specialist, and hence by common consent they are regarded as beyond the pale of the practicing physician.

4. Superficial Inflammations.

My last division embraces those diseases which under ordinary circumstances the family physician is called upon to treat, and I would name them as follows: Conjunctivitis, Blepharitis, and Keratitis, all the structures affected being easily accessible and the detection of their diseases requiring no special instruments except a trained eye.

CONJUNCTIVITIS.

The ordinary "sore eye," "cold in the eye" or the epidemic "pink eye" as seen by the physician is the usual Acute Catarrhal Conjunctivitis. The symptoms are hyperæmia of the conjunctiva, an injection of the ocular and palpebral vessels, more or less swelling, most marked in the lids and but seldom occurring in the conjunctiva covering the eye-ball; lachrymation, pain of a smarting, scratching, burning character, photophobia, and inability to use the eyes.

In conjunctivitis there is a discharge of a mucous or mucopurulent character, which is always contagious. In some cases it may amount

to little more than an increase in the amount of epithelium and normal secretion. As the discharge increases in quantity it becomes more and more purulent. At night when the lids are closed and motionless, the discharge dries along their margins, gluing them together so much so that in the morning they can be opened only with difficulty and after soaking in warm water.

The Treatment of Conjunctivitis consists in rest of the eyes, bathing in hot water at frequent intervals, and the instillation of a mild astringent Collyrium, as Boracic Acid, Borax, Camphor Water and Water, and the application to the edges of the lids of an ointment of Boracic Acid and Vaseline. In some cases a solution of Cocaine affords much comfort. In cases of long standing a more decided astringent as Sulphate of Zinc or Sulphate of Copper is required.

In those cases of intense inflammation accompanied with profuse discharges of pus, and is found in Gonorrhœal Ophthalmia and Ophthalmia Neonatorum, there is imminent danger of ulceration and perforation of the cornea, with subsequent opacity and loss of vision, and the treatment must be prompt and faithfully carried out. Thorough cleansings of the conjunctival sac every hour or even every half hour with an antiseptic solution, the instillation of a solution of Nitrate of Silver once or twice a day, and perhaps the use of Atropine, are urgently called for.

BLEPHARITIS.

A chronic inflammation of the free margins of the lids is known as Marginal Blepharitis. It is often associated with conjunctivitis. The symptoms are redness, swelling and itching, all of which are aggravated by use of the eyes, by smoke, and by atmospheric impurities. There is an induration around the sebaceous glands, with the formation of minute pustules, which rupture and leave small ulcers. The pus dries and becomes matted with lashes. When the crusts are removed, the edge of the lid may bleed and present an excoriated appearance. The lashes fall out freely and many of them are never reproduced. The lid is thickened, and the few remaining lashes are displaced and form "wild hairs."

The treatment (when not due to eye-strain) consists in the removal of the scabs or crusts by soaking with warm alkaline lotions once a day, the application of the ointment of the yellow oxide of mercury to the edges of the lids, and of astringent collyria to the conjunctival surface.

KERATITIS.

Inflammation of the cornea is quite a serious disease. The symptoms are pain, intense photophobia, and excessive lachrymation. The cornea loses its brilliancy and transparency, and the acuteness of vision is markedly impaired. In health and rarely in disease are there any blood vessels in the cornea, but there is in inflammation an intense injection of the peri-corneal zone. Ulceration of the cornea is not infrequently met with, is inflammatory in character, and shows marked tendency to perforation. In interstitial keratitis, the cornea assumes the appearance of ground glass.

In all forms of keratitis the use of those astringents that are suitable in conjunctivitis are contra-indicated, and instead only soothing applications should be employed. The pupil should be kept well dilated with Atropine, and the outside of the eye bathed frequently with hot water. The eye must be protected from light and kept from use. Insufflations of Calomel may be employed, or the application of the yellow oxide of mercury. Constitutional treatment is not to be neglected.

I have not attempted to present an exhaustive description of these diseases, nor have I indicated the treatment in detail. My thought was to make a mental map of Diseases of the Eye, and draw a broad deep line through it, separating them into two classes, one class beyond and one class within the province of the general practitioner, and then to do little more than reiterate the names of some of the diseases included in the latter class.

The family physician can hardly refuse to treat the usual cases of "sore eyes" that apply to him, but he should be constantly alive to their seriousness, and to the danger of mistaking them for some more deep-seated disease that may end in destruction of vision. This subject is such a vast one and these matters are all so important, that I feel as if some apology was due you for the superficial and imperfect manner in which I have referred to it.

DIPHTHERIA.

I. B. GILBERT, M. D., PHILADELPHIA.

THE age in which we are living is one of rapid advancement and improvement. Who is not able to recall, even within the period of a short lifetime, the wonderful achievements in all departments of knowledge.

In many departments the experimental stage is past.

In listening to a lecture of the late Dr. Pepper (several years ago) I heard him make this remark: "The science of medicine has made more progress in the last twenty years than in the past twenty centuries." This statement was rhetorical, it is true, but certainly we have made wonderful progress in the art and science of medicine. In advancing any theory, the deduction is made from the phenomena presented. But if all the data are not considered, the conclusion may be erroneous. This is the history of all antiquated and obsolete theories of science; later discoveries showed that very essential data were not considered or known, hence new theories were advanced, because the old ones were inadequate. At the present day that theory is accepted which will account for the greatest variety of phenomena, and hence is most reasonable. In the sphere of medical science that remedy is to be used which will combat the disease most effectually.

It is not a question as to what was the teaching of by-gone ages, but what is the practical utility of the measure employed. We are not bound to the dead past, but we move in the living present, and this living present dominates the mind often to receive new knowledge. It might appear as if I were inviting criticism and exposing myself to the charge of departing from the teachings of homœopathy in presenting my method of treating diphtheria. But if I understand Hahnemann aright, you will find that he followed precisely the principle which I advocate.

Hahnemann advocated his system because he believed that by following it the greatest good could be accomplished to the greatest number. I advocate my method of treatment on precisely the same principle. Whether anti-toxine is homœopathic or not is therefore not the question at issue. If the treatment is more successful than

any other, no matter what the principle that leads to the prescription, the question is practically settled beyond all cavil, at least to reasoning men and practical physicians. The so-called wise men of the present day give too literal adherence to the words of Hahnemann and lose sight of his principle.

He made discoveries and departed from the practices then in vogue, giving to the world a more scientific method of administering remedies. But were he living at the present day, and in possession of later discoveries, we venture to assert that Hahnemann would revise some of his theories. Therefore, to be true to ourselves and our profession, we accept results, cleaving to that which is good and relegating to the past methods that have not proven as successful as the new.

In taking this position, I would by no means wish to be understood as dishonoring or casting aspersion upon what has been taught, but with all due respect I esteem the courage which is exhibited by any man to depart from old lines of practice because he has found something better. We all labor for the benefit of mankind.

In the presentation of my paper on the subject of diphtheria to this Society one year ago, my purpose and object was to discuss in a general manner the use of anti-toxine in diphtheria. In the present paper I will confine myself to the practical, clinical phase of the subject, endeavoring to elucidate the manner in which I have succeeded in handling this disease which causes every physician so much anxiety as to its successful treatment. In combating diphtheria certain essentials are to be observed. These are, a suitable room, proper nourishment, and complete rest in bed, together with stimulation and hyper-nutrition. When called to treat a case of diphtheria I have the patient isolated by being removed to a suitable room. This room should be large, well-ventilated, and be so situated as to admit plenty of sunlight, if possible. All unnecessary furniture, carpets and hangings should be removed.

This leaves the room with a bare floor, that must be scrubbed or mopped daily with a solution of Carbolic Acid or Bichloride of Mercury. This adds materially to the purity of the atmosphere of the room and the well-being of the patient and nurse.

The nourishment should be abundant and regularly administered, consisting largely of liquids, such as broths, milk, etc. This matter of giving food often becomes a difficult problem, especially with young children, owing to their positive aversion to all food, and to

the difficult and painful deglutition. If other methods of giving food fail it is necessary to resort to nasal or rectal feeding.

Rest in bed is no less important than nourishment, but directions for its observance are more easily given than carried out. It is a difficult matter to keep a child in bed, and in spite of our strictest injunction on leaving it is not an unusual thing at the next visit to find the child in the mother's lap. Stimulants are used by a large majority of practitioners, and the indications for their use are marked prostration, a feeble pulse and a failing heart. My own personal experience is that I seldom succeed in getting the patient to take sufficient quantity to be of any marked benefit, especially in the very young.

We need no better proof that the treatment of diphtheria in the past has not been satisfactory than the fact that a great number of remedial agents have been brought forward in the treatment of this disease than any other. The entire battery of the materia medica has at one time or another been brought to bear upon it. Diphtheria is peculiarly a disease that needs close attention and medication. Nature does not often cure this disease, but medicine may and often does. Therefore upon the strength of this assertion I will briefly give my experience with the use of drugs and other measures in the treatment of this dangerous disease which calls for the most energetic administration of the most positive germicides, both locally and systemically.

My list of remedies in the treatment of this disease are very few in number, but very decisive in action, namely, Merc. Bin. Jod., Kali Bich., Echinacea, Chlorine and Anti-toxine. I do not wish it understood that I do not employ other remedies when indicated, but I do mean that I am willing to go into battle against diphtheria with this ammunition to draw upon. You are all familiar with the use of the remedies named. I will briefly occupy your time therefore in describing the preparation and use of Chlorine as it was given to me by the discoverer.

Take a four-ounce dark bottle, put in one dram of Potassium Chlorate in coarse powder or crystals, and add minims 20 of C. P. Hydrochloric Acid; stopper the bottle and apply gentle heat until it is well-filled with gas; do this prudently to prevent a possible explosion. Now pour into bottle a small quantity of cold water, cork well and shake briskly, add more heat, then more water, and so on until bottle is filled with Chlorine water.

It is now ready for use. Make fresh for each case. Use no metallic spoon or vessel of any kind in its administration. Take one dram of the Chlorine preparation, then add sufficient water to admit the solution being readily swallowed, one-third to one-half glass water according to age of patient. This portion should be taken in three or four hours' time by swallowing a small quantity after rinsing mouth well with hot water, taking nothing else for ten minutes after, so as to allow the remedy to remain in contact with the throat as long as possible. It is especially valuable in laryngeal cases.

Now as to anti-toxine? I shall confine myself to a consideration of my personal experience with the serum treatment. Here we enter at once upon debatable ground, for it is an admitted fact that the medical fraternity is about equally divided upon the question as to the merits of diphtheria anti-toxine. My own experience justifies me in the conclusion that a physician renders himself liable to just censure in failing to apply a remedy so generally known, so remarkable in its work, and so gratifying in its effect in cases where it is called for.

This is a broad assertion, but I am willing to stand by it. It is possible that all cases do not need anti-toxine, and to this class this is the one loop hole I allow to non-users of anti-toxine. Personally I have one guide only in using diphtheria anti-toxine, and that is, to employ it as soon as I have made my diagnosis. My observation and experience thus far teaches me to employ the injection early, and to repeat the injection in 12, 16 to 24 hours, unless marked improvement is noticed. This favorable change manifests itself in many cases before 24 hours by the patches ceasing to spread, the loosening and curling up of the edges of the membrane, and the general amelioration of the symptoms of septic infection.

In several of my cases have these results been brought about so promptly as to seem almost incredible. Since using the serum treatment I do not fear or approach the laryngeal variety with that same timidity as formerly. Like every practitioner who has been taught by the experience of quite a number of years of active practice, I had adopted my own method of treatment for diphtheria, and with fairly good results, too, that I was very reluctant to abandon it for the new serum treatment.

How the change was effected the following case will explain: The patient was a very bright and promising boy, and the son of an intelligent father, who was well-informed not only concerning the new

method of treatment, but also of the necessity of employing the strictest antiseptic measures in everything pertaining to the treatment and the care of instruments used. The case was developed and the symptoms so pronounced that I gave my diagnosis without hesitation, and with it a very unfavorable prognosis. The father suggested the anti-toxine treatment, to which I objected, preferring to treat the case on my own lines. He promptly informed me that if I would not use the treatment he would call in some one who would. At that time I was in the same position mentally that some of the members of this Society now are; that is, I was afraid of anti-toxine, doubted the reported results, and was skeptical as to its efficacy in this particular case. I must thank the layman for being so persistent. My eyes were opened. There being no alternative, I agreed to use the new treatment, under the condition that I was not to be held accountable for the outcome of the experiment. His reply was: "See to it that your syringe is thoroughly disinfected and I will assume all responsibility." The injection was given, and we had the great satisfaction and encouragement of noticing a slight improvement of his condition in two hours by a change in the color of his lips. In four hours from the time of the injection expectoration was established and the membrane began to loosen, and after 24 hours I considered the patient out of danger. A good and uninterrupted recovery followed.

I will cite but one other case, one that completed my conversion to anti-toxine. Female, aged thirteen years; light, fair and slight in build, of an extremely nervous temperament; found her suffering from an aggravated attack of laryngeal diphtheria of 24 hours' duration; the symptoms were such as past experience had taught me presaged a fatal termination in less than 24 hours, unless relief was obtained. Prognosis unfavorable; suggested the use of anti-toxine, which was granted, and immediately administered 1,500 units and awaited results. Noted some improvement in 12 hours, but not considering it sufficient was followed by another 1,500 units, which was attended with marked amelioration of all the unfavorable symptoms.

The interesting and rather unusual occurrence in this case was that six hours after the second injection a most fearful dyspnœa, accompanied by a deep cyanotic condition, followed by a terrific paroxysm of coughing, choking and strangling, until finally she ejected almost a perfect cast of the larynx, proving the correctness of the diagnosis. An uneventful recovery followed. My experience with these cases are typical of many others that I have since treated on the same plan.

I am aware of the fact that some who do not indorse the use of anti-toxine may be ready to say that there may have been a mistaken diagnosis in the cases that recovered under its use, or that recovery may have been due to other remedies given at the same time. While this may be true to a certain extent, or may not, I will say that prior to the use of serum treatment these cases usually terminated fatally in spite of all treatment that I ever adopted, and after searching all authorities for aid in vain.

Anti-toxine will not cure all cases, or rather does not cure all its cases, for the simple reason that it primarily is too often used too late, and secondarily because the labor and the strength of the workman are too often entirely out of proportion. Some cases are bound to die no matter what treatment is employed. I am simply advocating anti-toxine as the best known and most successful treatment of diphtheria. Both facts should not count against the remedy, for we as medical men know how frequently other remedies are considered impotent and the prescribers weak. So it is too sweeping to condemn a remedy because it does not accomplish the impossible. How many times are medical men called to examine throats where little short of a miracle could be expected to avert dissolution? If anti-toxine is used it is blamed for the failure that was to all intents and purposes unavoidable with the condition existing.

Now it is too often the case when articles are written and presented on any subject that the successes are heralded all through medical literature, while failures are kept in the background, or not even touched upon at all; especially has this been the case of this very subject under consideration. This is both misleading and unfair treatment to any subject or remedy, as we often are benefited by our mistakes or failures. To say that I have had no failures with the serum treatment would be erroneous, but now that my percentage of mortality has been greatly reduced is stating strongly my reason for using it. On the whole, my experience has been so favorable that I am inclined to believe that the majority of failures must be attributed to the neglect of antiseptic precautions, such as unclean syringe perhaps, or failure to cleanse the part where the syringe is to be introduced. The instrument must be immediately cleansed after use so that none of the serum may dry in the barrel, and by decomposition poison the next patient.

I hold that we should use the best of everything and acknowledge it, no matter from what source it comes. It would be wise for all

medical practitioners to follow the advice of Paul, "Prove all things, holding fast to that which is good."

DISCUSSION.

Dr. A. B. Lichtenwalner: The President asked a question. He would like to know the source of anti-toxine. I would say covering the subject of serum treatment, the idea of the anti-toxine treatment has been proved by different cases of virulent diphtheria, proved by different injections into the guinea pig and then followed by injections of a coagulated form; then followed by injections into the blood of a horse.

Dr. C. C. Rinehart: Where did you obtain the anti-toxine that was efficient?

Dr. I. B. Gilbert: It is unprofessional to advertise a particular firm, but I will say that I use Mulford's preparation.

Dr. C. C. Rinehart: I want to learn which preparation is reliable. You would not hesitate a moment to say that you obtained an excellent drug from Boericke & Tafel, and I do not see why, if there is a thoroughly safe material, we should be kept in ignorance as to where it was purchased.

Dr. I. B. Gilbert: The reason I said that was because I know a physician who several weeks ago was called to task terribly for that same reason.

Dr. A. P. Bowie: There is one criticism I would like to make in reference to the fact that Hahnemann's theories were criticised in the paper. If I have read Hahnemann's writings aright he was no theorist. Theories had been the bane of medicine until he came on the field of action, and it was to introduce certainty in the practice of medicine that he made his experiments and published them to the world. We can prove what Hahnemann has proved and verify his statements by our own experience. I always dislike to have it said that Hahnemann was a theorizer, because he was no theorizer. He did not say that homœopathy was the only way of treating disease; he acknowledged that there were other ways of treating disease, but he gave the homœopathic as the best way. Therefore, he advocated it.

Dr. Berlinghof: I reported 130 bona fide cases of diphtheria to the Board of Health in Scranton, which were confirmed by a bacteriological examination, and my mortality was less than five per cent. —those which died having been cases that were far advanced—and I

lost one case in which I was compelled to use the needles without thoroughly disinfecting them. One point the doctor brought out about thoroughly disinfecting the needle and syringe is a very important one.

Dr. Theodore Sureth: In this epidemic that Dr. Berlinghof spoke of I used anti-toxine very extensively. One case was of laryngeal diphtheria or membranous croup. In this case I did not use the anti-toxine. I used the usual remedies. At the end of about forty-eight hours the case responded and got along, as I thought, very nicely. My last call was in the morning about 11 o'clock, and I found the child had had some rise of temperature, but that condition had subsided and the child was very much better. That evening I was called about 7 o'clock and the child was in convulsions, and what diagnosis to make I hardly knew. I washed out the intestinal tract, gave the remedies indicated, but the child went on with convulsions—regular opisthotonos—and the convulsions came about every fifteen or twenty minutes. Twelve o'clock that night I was called again. The next day the child was still no better. I concluded that some toxine of diphtheria was still in the system and was acting on the spinal membrane. With that in view I went for the anti-toxine and injected it; the child had about three convulsions after that and went on to prompt and rapid recovery.

Dr. O. S. Haines: I never feel like talking about anti-toxine, because it always brings up harassing memories of unfortunate events in the past. I have seen a number of cases that have not recovered under the anti-toxine treatment, and, at the same time, if I were called to a case of diphtheria tomorrow, as soon as I could make the diagnosis I would most assuredly use the anti-toxine treatment. When such testimony as that which Dr. Gilbert has given, and also a great many of my friends, in whose integrity and skill I have the greatest confidence,—when such testimony as that is given, I think it is my duty to accept the anti-toxine treatment as the best treatment, and yet in my experience I have been most unfortunate. I have not seen a brilliant result, but I would use it, on this testimony, in another case.

Dr. A. B. Lichtenwalner: I think Dr. Gilbert covered the subject thoroughly. The drift of my paper is that we should simply look upon the anti-toxine treatment as the child of no school, but as a boon to humanity. Dr. Gilbert has covered the subject so thoroughly that I think it would be taking up time which we could utilize to better advantage to discuss the subject further.

NORMAL DEVELOPMENT OF INFANCY.

W. M. GRIFFITH, M. D., PHILADELPHIA.

THE birth of every living child adds one to the census of the country. Independent life begins at the moment of expulsion, and when the cord is severed the last anatomical connection between mother and child is cut off forever. In one instant the child is transformed from unconscious repose, solitude and darkness to light, action and the beginning of visible life. From being surrounded by a bland fluid of unvarying warmth it passes at once to a rude contact of an ever-changing and colder air, and to a harder pressure even from the softest clothing.

Previously nourished by the mother's own blood it must now seek and digest its own food and throw off its own waste. It must now generate its own heat, oxygnate its own air through its own lungs. Its own nerves must now receive and communicate its own impressions.

Such is the revolution which occurs in the mode of life of the new-born infant and such are the changes for which its organization must be already prepared at the instant of birth and which renders the period of early infancy so full of danger when their nature is misunderstood and the treatment is not in harmony with the wants of the constitution.

Without doubt sensation and muscular motion are the first functions roused into action by the sudden entrance of the new being into the outer world. According to physiological observation, before the infant can begin to breathe and to circulate its own blood the stimulus must be felt which renders breathing an imperative act. The excited sensibility of the nervous system is thus the primary source of the impulse which calls the lungs into play. At birth the posterior portion of the brain (motor portion) and nerve centers are well developed, much more so than the anterior or intellectual parts of the brain.

The health growth, usefulness and I might add happiness depends on the normal performances of the functions which begin at birth and the function of digestion which begins a little later.

The shout or cry of the new-born is usually a great relief to the parturient and a satisfaction to the physician and those in attendance, and we watch with interest the changes of color of the skin as oxygen enters the air and blood cells and the skin turns a reddish hue from the process of respiration acting on the capillary circulation of the blood.

The child at birth is helpless and unprotected. Without assistance it would soon die. What help shall we render and what protection shall we give?

Soon as the function of respiration is established I proceed at once to lubricate the infant, greasing it thoroughly while it is warm. At this time it can be done very quickly, and every moment saved is an advantage to the child.

In cutting the cord I often govern myself according to its size. If small and flabby I tie in two places and cut between; if large and full of blood I tie in one place, cut the cord between this point and the child, which allows the blood to escape from the cord, which reduces its size and facilitates its final separation; then the child end is tightly tied.

When the infant is lubricated and the cord tied it is my preference to proceed at once to have it washed. To do so quickly we must have a good-sized china or stone basin half full of quite warm water, a clean flannel rag and white castile soap, or ivory soap. The baby is put into the wash bowl containing the water and quickly and thoroughly washed; the vernix caseosa is easily removed.

My preference in dressing the cord is a soft linen piece. I have tried absorbent cotton, but I fancy it tends to preserve the cord rather than hasten its separation. The piece of linen is perforated, cord put through it and smoothly wrapped, the free end directed upward and slightly to the left and secured by a flannel bandage. Thus in a very few minutes from birth we have a clean baby, with cord dressed and band on, and the nurse is ready to complete the toilet, when it is wrapped up snug and warm and laid away to rest and sleep.

Amateur baby-washing or the movements of a slow nurse ought not to be tolerated on such an occasion.

Infants during the first week, perhaps the first month, or even longer, ought to sleep 20 hours out of the 24. During their wakeful moments the function of digestion must be brought into action. The whole physiological development of the new-born child is determin-

ed by the character of the food that is given to it. Hygiene at this time deserves the attention of all interested.

It has been estimated that the minimum rate of mortality of children under one year old is 100 per thousand. Often it reaches 200, or even more. The minimum rate is greater than it should be and ought by proper management to be reduced to 70 or 80 per thousand. The chief among the causes to which the large proportion of deaths is ascribed is artificial alimentation. The mortality is rated according to the way the child is brought up, and great differences is noted between children brought up at home and that of children intrusted to hired nurses, and the not less marked difference in the rate of mortality of children nursed at the breast and of children artificially fed. The recent hygienic congress of Paris (1878) discussed this subject, and according to their statistics found children of the easier classes brought up at home the rate of mortality often falls as low as 70 or 80 per 1,000; children intrusted to nurses would vary from 240 to 750 per 1,000; among those fed by bottle, 51 to 100. (Popular Science Monthly, Vol. XVII., 1880.)

The infant, after a delay of a few hours from its birth, say anywhere from 4 to 8 or 10 hours, ought to be prepared for nursing, if not already done. Its mouth should be washed and the mother's nipples moistened and cleaned; then an effort should be made to have the child nurse. The child to the breast with a good supply of healthy milk is fortunate indeed, for if this source of food supply fail from any cause or at any time during the first year of the infant's life, it is often a calamity to all concerned, and the feeding after that fails is largely experimental. We are well aware that a great many foods are in the market, and many theories advanced for artificial feeding of infants, so also as physicians, we are aware that each child has an individuality of its own, which must be studied, and we must find out if possible the food suitable for each case.

An interesting article, by Dr. Wm. Owens, of Cincinnati, on "The Importance of Diet in Diseases of Children," is published in the Transactions of the American Institute of Homœopathy for the year 1891. In the discussion on this paper Dr. J. B. Gregg Custis said: "We ought to remember about the discharge; if the child is habitually constipated the food is not strong enough for that infant, whilst in the absence of disease if the stools are frequent and loose the food is too strong for that particular child."

We cannot adopt these suggestions as a positive rule, but it may

aid us in coming to a conclusion when a certain brand of food is being employed and the question is asked: Is this the proper food for this particular case?

I now forbid nurses giving an infant sweetened water at any time—it certainly is a fruitful source for colic—and if nursing is contemplated the only thing to give is pure, warm water, and what the babe can get from the breast. Then when the milk train comes in on the third or fourth day we have a hungry infant, ready to relieve the breast, and do its duty towards getting its own nourishment. If the babe is to be fed artificially, then let it have milk and water in the following proportion: Milk one-third, water two-thirds, slightly sweetened; this will usually satisfy for a few days, when more food will be required. A good formula is one tablespoonful of cream, two tablespoonfuls of milk and three tablespoonfuls of water. This properly heated and sweetened usually agrees with most of babes artificially fed.

The physical growth of the infant and its proper food is a never-ending study, for hard and fast rules cannot be put in cold type and be made to fit every child. Every child has an individuality of its own. The child has not only a physical growth, but also a mental growth. Mind at birth is a blank. What motions and functions start are automatic.

We find the germs of all the faculties in the little child. Sensations are the food upon which the faculties grow.

While the mind is a blank the essential faculties are innate, for the nervous centers that manifest them are already organized at the time of birth. A child has the germs of ideas long before he can give them articulate expression. It is a tax to his ingenuity in order to convey by intelligible signs the thoughts which arise in his mind. I cannot find any literature on the subject which shows how soon after birth the mind begins to develop. My own impression is that thought at first must be very crude. If it could be demonstrated it might be represented by a single cell. This single cell is the first idea, crude and unassociated with any other idea. The second idea means a second cell, and so on till the mind is well stored. The training of the mind brings the cells in their proper relation to each other, and as we add to our knowledge the cells continue to adjust themselves and their proper relations are arranged according to the knowledge obtained.

There must be a limit to the multiplication of ideas and the growth

of cells, but I cannot conceive of a limit to their frequent change of relation which adds to our learning and experience.

The manifestation of feeling in an infant, such as pleasure and pain, Nature has endowed him with adequate expression. The states of discontent and content, misery and gladness, pronounce themselves with a clearness and emphasis which leave no room for misunderstanding.

It is said the first manifestations of pleasure in infancy are due to *taste*. A child two and a half months old will make grimaces when offered a sucking bottle filled with water or milk too little sweetened. The sense of touch is early developed. The passing of a feather over the eyes and nose of a child 15 days old will make it frown. Agreeable sensations are manifested in about two months. They are very susceptible to variations in the temperature. Infants die easily of cold, even in summer, and intense heat is often fatal. It is likely a child has vision at birth, color soon attracts, lively colors charm, dull colors also please if they are positive and distinct.

There are signs that the babe hears early, and often it will be pacified much easier if the mother adds a lullaby when nursing or rocking it. One child a month old liked to listen to playing and singing. From four to six months old almost all children appreciate singing, and many begin to prattle.

Children for a long time show no sensibility to good or bad odors. At ten or fifteen months their sense of smell is very lively.

Fear is early manifested. A babe two months old will make a face, cry and recoil upon the bosom of its nurse if one sneezes or cries out near it.

Anger and jealousy. At three months a child will frown, make a wry face, kick and cry on seeing another babe on its mother's breast.

Movements. A new-born child will sneeze as well as cry.

During the first week a babe sheds no tears.

Little ones have an instinctive horror of isolation. Whoever studies them knows that when awake they look not at first with staring eyes, but with searching hands. They seek not for sight, but for contact. *Smiling* often occurs before the age of a month. Children of two months laugh, but without seeming to suspect that the laugh expresses anything. Children raise and lower their leg with no apparent reason. A babe a few minutes old I have seen suck its fists. Children have only a germ of sympathy, and they show signs of it as early as one year.

The lingual development of children must depend on the development of certain brain and nerve tissue, which tissue is the center of the function of speech. While the germ of speech exists at birth its successful development requires time. The time required is not the same in every child. Many a bright mother hears words uttered by her child long before any one else. We have many a volume on the development of the teeth and on diet, but what few authors have written on speech, the use of which enables us to communicate freely with each other!

We know it is recorded "that the tongue is an unruly evil, and every kind of beasts and of birds and of serpents and of things in the sea is tamed and hath been tamed of mankind. But the tongue can no man tame."

At eight or nine months some children make an attempt to say a few words, such as pa or ma. They also babble, babble away, making unintelligible noises. This babbling ceases in proportion to the advance in articulation, and stops altogether when talking has been established. Many a child a year old has mastered quite a number of words, mostly monosyllables, which are uttered distinctly. New words are gradually added to his vocabulary, so by the time he is two years old sentences can be spoken and he will attempt almost any word which he hears.

The language, the idiom and the dialect of the child reflects the language, the idiom and the dialect of his teachers, for children are great imitators and their first knowledge of speech comes from hearing others talk.

Impressions made at this early time, whether for good or bad, are often indelible, and his actions are often influenced by these impressions when he has reached more mature years.

The process of dentition is too well known to dwell on at this time. With proper nourishment and good surroundings the teeth will grow, even if there should be defective mental powers.

Walking, like talking, must be learned. Teeth will grow without a teacher, but a child must have an imitator to learn how to walk, as well as how to talk. A few children as early as eight months will stand on their feet, and I have heard of some walking at nine months, and know of instances of children walking when eleven months old. The majority, however, are from twelve to fifteen months old when they start afoot for themselves.

When we consider that a child starts in life with nothing but its anatomy, it is astonishing how much it learns by the time it is five

years old. The senses, seeing, hearing, smelling, tasting and feeling, are in active operation; it has learned to talk and walk and help itself in many respects. Perhaps more important and valuable information has been learned in this time than it will learn in any five consecutive years in after life.

The physician is so accustomed to study children from a clinical point of view that I hope this digression will be refreshing to your pure minds by way of remembering that there are some children that pass the period of infancy without serious sickness of any kind. A study of the natural healthy child may assist us in detecting any deviation from the normal conditions.

The misfortunes and diseases that children are liable to are so numerous that many volumes by intelligent authors have been written on the subject.

It is misfortunate for a child to have had a diseased parent or parents. It is helpless in its innocency. The chances of a child reaching maturity are very much lessened if one or both parents have had scrofula, tuberculosis or syphilis. Children of this inheritance are much more likely to contract diseases during childhood, and often with fatal result. I believe inherited diseases make their greatest impressions on their victims in infancy and childhood, and if the child survives this period it has an equal chance of living out its expectancy as other children of equal age and surroundings.

The innovation of the homœopathic physician during the present century, together with his pleasant and effectual treatment, his urbane manners and diplomatic examinations, and management of infants and children, has largely banished the terror that formerly prevailed among children when the name of a doctor was mentioned, and has largely revolutionized the medical and surgical literature.

We have great respect for the old authors that braved the tide of medical ideas, and wrote upon the new method of medicine, and scattered broadest their literature in the shape of tracts, treatises or larger volumes. We also honor the new men that have kept pace with the times and write up-to-date works that will compare favorably with any medical volumes, nor do we ignore any reliable author.

In discussing the subject, I hope you will give us your personal experience with children, whether in health or sickness.

DISCUSSION.

Dr. R. E. Tomlin: In reference to the question of the development of the child up to five years, I would say that it is stated by the

most eminent kindergarten experts that the most active period of one's life is about three years, from the second to the fifth; I presume that is true.

Another fact is that some children who fail to articulate until very late, when they do begin they talk very much better, use very much better language, speak in a more distinct, more clear-cut manner, than those who, when a year old, begin talking. For instance, I have seen and know children up to three years of age who could scarcely say more than oo—oo—oo; when they did talk their ideas and expressions were clearer than the children who talked at much younger age. I think many of the thoughts expressed in the doctor's paper ought to be considered by us very much more than they are. What a common thing it is to see a nurse take a baby and every day dip it in the tub. I have asked them time and time again if they bathe every day, and their reply would be, "Well, I have not had a bath for two or three weeks." The inconsistency of the thing is apparent. The weak lungs and kidneys and affections of early childhood are due not only to indiscriminate drugging, but also to the hygiene to which they are subjected by the nurses.

DISCUSSION OF GASTRIC ULCERATION AND ITS TREATMENT.

OLIVER SLOAN HAINES, M. D., PHILADELPHIA.

I DO not suppose that I could have selected a topic for discussion, that is, at the present time, better understood by the majority of the profession than "The Treatment of Gastric Erosions and Ulcers." Our text books agree very generally that there is but one safe method of successfully dealing with these conditions, and the principal reasons for mentioning this matter before the Bureau of Clinical Medicine and the Society are these: I have an impression that all cases of gastric ulcer are not even yet treated according to the rules of the plan which I have already referred to as the best plan. It would be interesting, therefore, to hear the experiences of those gentlemen who have followed other plans of treatment than the one laid down in the more modern text books. Besides this, the subject is by no means a trite one. It has not been worn threadbare by too frequent discussion, as far as I am able to judge. I trust we shall have a good dis-

cussion, because it is only in this way that one learns how to interpret his own personal experience, and upon this of course will depend in large measure his future course of action. I have taken as the basis for this discussion the records of twenty-six cases of (well-defined) gastric ulcer, from which I have attempted to cull some of the most conspicuous facts.

I am quite sure that up to the time of meeting with one particular case belonging to this series, a young woman aged twenty-five years, I was unconscious of, or perhaps I should rather say indifferent to, the existence of a variety of the chronic eroding ulcer of the stomach which runs through its course to a fatal termination in a very short and dramatic fashion. This young woman came to my office one morning and informed me that she had been troubled for the past week or so with an attack of indigestion. It was very unusual for her to have any complaint of this sort, as she prided herself upon her robust health and freedom from complaints of a physical kind. Moreover she was not pleased with her regular physician because he had looked lightly upon her symptoms and had simply ordered her to be careful in her eating for a few days. She told me that the lightest food had, for some weeks past, occasioned her great pain directly under the end of her breast bone, and that she was so tender there, that she could not wear her corsets. She had also vomited after eating a number of times. As I have said, she had been in excellent health previously, and indeed had then the appearance of good health. I remember distinctly that at the time of my first seeing her, I suspected an ulcer of the stomach, but did not mention the fact to her. I told her to take nothing save four ounces of milk every four hours, and to remain at rest. She was to report in several days. She did not so report. After a week had elapsed, one of my old patients came to inform me regarding the young woman, that a couple of days after her visit to my office, while she was walking along the street, she was seized with a sudden hæmorrhage from her stomach, was picked up and conveyed hastily to a nearby hospital, at which place she arrived dead. A post morten examination showed a single deep perforating ulcer of the stomach. I repeat that this case opened my eyes to certain possibilities to which I had previously been indifferent.

Ewald, in his extensive experience, had doubtless some similar cases; for he remarks that " the name chronic eroding ulcer of the stomach" is not quite correct, because it is occasionally acute." It must become quickly apparent to anyone who will study his cases, that such etiological factors as,—the ingestion of very hot food or

drink, or of food imperfectly masticated, or of sharp spiculæ of bone or other harsh substances, or blows that are received directly upon the epigastrium, or violent efforts at vomiting, or violent convulsions, etc., etc., should not and do not occupy the foremost place in the causation of ulcer of the stomach. The patient invariably exhibits such a complex clinical picture, that it is clearly suggestive of many other underlying determining factors besides those mentioned.

They are generally sick men and sick women outside of their ulcers. Indeed, in but two of this series of cases could any of the causative agencies just mentioned be recognized, save by a stretch of the imagination that is never justifiable in our dealings with sick men and women.

The presence of simple anæmia, with or without menstrual irregularities, was very commonly noticed in the women. In all so affected this had clearly existed previous to the development of their gastric ailment. There was generally enough evidences to point to a neurotive temperament. There was also as a rule enough evidence for us to say positively that the patients had been in the habit of taking into their stomachs insufficient food, or food of low nutritive value. We will refer to this again. Some of the women were chlorotic in appearance. Whenever the blood was examined there was a noticeable decrease in the percentage of hæmoglobin, or coloring matter. A chemical analysis of the gastric contents was not invariably made, but when made it showed always hydrochloric acid, and in several cases an increased proportion, amounting to a hyperchlorhydria.

In this small series of 26 consecutive cases seen during the years 1896, '97, '98 and '99 all were women save three. The women ranged in age between 22 and 35 years. Out of the 23 women over sixty per cent. were cooks, or domestics, who also did cooking. This fact has seemed to me a curious one. I have thought that lack of fresh air and lack of daily exercise in the fresh air, together with a habitual diet of foods of insufficient nutritive value, ought to be given very prominent places among the influences which predispose to the affection under consideration. It is a well known fact cooks and domestics are habitually exposed to just those influences. I am not a vegetarian myself, yet I do not believe a diet of bread and tea, or even bread and tea and meat, will produce a very high grade of either mental or physical vigor.

One of my cases was rather extraordinary in its pathological anatomy. The woman had presented fairly classical symptoms of

the malady for upwards of ten years; and during the last three years she had been practically an invalid, spending most of her time upon the bed. She was constantly under observation and treatment. She finally died three days after having drank a glass of lemonade, or rather a mixture of lemon juice and water, much stronger than ordinary lemonade should be. At the autopsy there was found the cicatrix of what had been a continuous ulceration or necrosis of tissue extending along the greater curvature and anterior surface of the organ from the cardiac to the pyloric ends, while near the pylorus there was found a deep perforation quite typical in its oval step-like depression.

She presumably had lived for three days after the perforation in a state of very profound collapse, being kept alive perhaps by vigorous hypodermatic stimulation, with strychnia, etc. The appearance of the cicatrix gave one the impression that the extensive necrosis of the stomach wall had healed as it had progressed. It has been a matter of regret to me that this case had not been treated at any time during her long illness upon the strict lines laid down in our standard works. She had never been deprived of food by the mouth entirely, nor had she ever been fed exclusively by the rectal method for any length of time. It has also been much regretted that this case was allowed to procure the lemonade, which apparently hastened or caused her death. I would not allow any case having symptoms of gastric ulceration lemon juice, nor lemonade.

In studying the symptomatology of these cases the following facts have appeared to deserve a prominent place:

The patient was generally a woman and generally anæmic. The blood examination confirmed this. There was generally a number of "nervous symptoms" to be observed. Menstrual irregularities were common, generally in the direction of scanty, pale flow, with or without pain during the periods.

The tongue was not usually coated to any extent. The presence of a heavy fur upon the tongue would indicate the co-existence of a catarrhal gastritis. Other symptoms would then confirm this. Appetite is not usually actually impaired in uncomplicated cases, dread of pain, however, soon produces a habit of eating very little food, and only such lighter articles as did not inflict punishment after they had been swallowed.

The histories very commonly showed lack of food rather than excess. A dietary not varied enough. A predominance of one kind of food, such as meat, to the exclusion of vegetables and fruits. A lack of fresh air and sunshine. The bowels of these patients were almost

universally constipated. Several factors were probably responsible for this, such as pain, insufficient food, food of a sort producing little intestinal debris, etc. Diarrhœa when it occurred seemed to have been accidental.

But slight fever was noticed in any of these cases. 99.2 or 99.5 degrees was the maximum. I noticed, however, quite frequently a subnormal temperature not occurring at any regular intervals, and being as likely to occur in the afternoon as in the forenoon. The lowest point reached was 96 degrees F. I sometimes thought that this abnormally low temperature was in some way directly related to the disease, but of this could not assure myself. Pain was invariably present, variously described, but always severe, always associated with a marked sensitiveness in a localized point. It was much aggravated by finger pressure over this spot of tenderness, and also by the ordinary pressure of clothing bands. It was common to see the clothing loosened or open in the epigastric region.

Dread of contact or pressure was always a symptom in these cases. Generally speaking, the ingestion of food increased this pain, or caused it to recur, when absent, in an increased intensity. One of these cases, however, suffered particularly when the stomach was empty or partially empty of food, say, two hours after eating. In other respects his symptoms were classical. This case was 48 years of age. His previous health had been fairly good. His habits had been rather lax. He drank. The ailment in this case seemed to have begun after the accidental swallowing of a large irregular shaped piece of gristle. Upon several occasions this case went into what was apparently a state of collapse. We feared internal hæmorrhage, but no blood was vomited, nor did any appear in the stools afterward. There was a catarrhal gastritis present in this case no doubt, and I was inclined to regard it as a case of duodenal ulcer, although he presented many of the diagnostic signs of gastric ulcer.

In about half of the cases the stomach pains radiated in various direction, principally towards the back or spine. Heartburn, waterbrash, flatulent distension of the stomach, loud eructations of gas were not common, but exceptional, symptoms. Vomiting of food immediately or soon after its ingestion was an almost universal symptom. Relief of pain, or even entire cessation of pain after vomiting, was also commonly observed.

Vomiting of small clots of blood, or blood in streaks or small quantities of free blood, was a symptom quite frequently observed.

In the three fatal cases in this series there were in each case large and frightful hæmorrhages.

The majority of these patients did not look emaciated, although all had lost considerable weight. Neither had they a particularly sick expression as a rule. They had all lost strength, however, and were unable to attend to their ordinary work. One case, a man, had lost forty pounds in weight during a comparatively short time.

I would not say that it is always an easy matter to decide positively that a given case has a gastric ulcer. We may, I think, generally decide upon the following clinical data, and adjust our treatment accordingly:

The fear of eating on account of the pain produced, with paroxysmal pain, severe in character, produced by ingestion of food, and sometimes drink. The exquisite tenderness to point pressure over a definite spot, generally just beneath the lower end of the sternum. The existence of this tender spot, even when the pain has temporarily ceased. The almost involuntary, sometimes violent, vomiting of the food when eaten or soon afterwards. The relief experienced from the act of emptying the stomach. The presence of blood in the vomited matters, or the easy vomiting of free blood. The history of previous similar attacks, or the history of a stomach ailment of long duration, with periodical acute exacerbations characterized by the symptoms just mentioned. The age of the patient (20 or 30, for instance).

The history of an occupation in which lack of sunshine, lack of out-door exercise, insufficient nourishment or careless habits of eating were prominent.

The co-existence of an anæmic state, with reduction in percentage of hæmoglobin and menstrual irregularities, if the patient is a woman.

The existence of a hyperchlorhydria, with persistent dyspeptic symptoms, and also occasional acute attacks of pain after food and vomiting of blood or food.

The absence of well-defined induration or tumor.

The absence of the physical signs of dilatation of the stomach. I have seen dilatation of the stomach once following an ulceration near the pylorus, presumably due to the cicatrization. I have seen it several times in cancer of the stomach, when the presence of the cancerous mass was not revealed at all, or but uncertainly by physical examination.

During the treatment of these and also other cases of gastric ulcer-

ation it was observed that it was impossible to establish a routine method of treatment that would be applicable to and successful in every case. I was glad to observe that the rule of therapeutics, which relates to the "individualization" of cases before the final adjustment of treatment to them, was as essential and applicable in this pathological condition as elsewhere. What I have just remarked applied particularly to the medicinal part of the therapeutic management of gastric ulceration. It was easily to be seen that but little curative effect may be expected from drugs selected directly for the morbid anatomy and supposed pathology of the case, without due consideration of those finer symptoms and signs which give to every case, no matter what its pathology may be, its own peculiar individuality. I would like to illustrate this by saying that I consider it to be a great mistake for any one to recommend, we will say, *Kali Bichromicum,* for instance, to another as a remedy likely to prove curative in gastric ulcer, for the reason that the ulcers produced by Kali Bichromicum bear some resemblance to the typical perforating ulcer of the stomach, as seen upon the post-mortem tables. Any therapeutic suggestion framed in this manner is most misleading, and moreover it distracts the attention from the real cause of the occasional efficacy of Kali Bichromicum in gastric ulceration; namely, its homœopathic relationship to a certain, distinct and peculiar and rather uncommon train of clinical symptoms and phenomena which occasionally accompanies one of these "punched-out" ulcers.

A very superficial experience with the remedy under present consideration will convince any one that it is really only very occasionally that Kali will do anything at all for the relief or cure of gastric ulcer. Any one who cares to do so can also ascertain without much labor the exact conditions under which the Kali is effective. It was so in but two of this series of cases, I believe. It was effective, and I believe will be so again under the following circumstances:

A high grade of gastric catarrh is probably present, as well as ulceration, because the thick, yellow, rough fur upon the tongue shows that; and the edges of that dirty member are curiously *scalloped.*

The epigastric distress of the Kali is not the commonplace pain of ulcer; it is a distressing *weight* and heaviness and oppression after food.

Food lies like a load upon the stomach for a long time, and burning is felt. There is much gagging and nausea, and even vomiting; these are commonly accompanied or caused by throat irritation; a

sense of a *hair* in pharynx for example was expressed not unfrequently.

The vomited matter in Kali Bich. is the food taken of course, but characterized I think by being either *sour* or *hot* in taste and containing considerable *mucus* (of a glairy sort) and some little blood.

You see the vomiting may come on immediately after eating, or within an hour or so after eating, but the concomitants are of more value in the selection of the remedy than the simple fact that the patient vomits, which latter symptom is well-nigh universally present in all cases of ulcer.

It is probable that the Kali is well-suited to cases complicated by either gastric catarrh, as we have said, or hyperchlorhydria. At least the symptoms produced by the Kali would indicate that, and my little clinical experience with the remedy has confirmed this impression.

The Kali Bich. patient is thirsty, as are most of our ulcer cases, but in *this* case water tastes unpleasantly, and there is a decided *craving* for the bitter of beer or malt.

I should say that the sore, or sensitive, "spots" in the Kali Bich. patient would be apt to be in the right hypochondrium, rather than just under the sternum, as is common in ulcer; although it has also a sensitiveness to pressure to the *left* of the xiphoid cartilage.

We know that it cures duodenal ulceration after burns, for instance, characterized by almost the same clinical phenomena as have been mentioned.

There are many other points to be considered at least before we select the Kali for our case, but I simply wish to enter a protest against the recommendation of any remedy for a definite pathological condition, simply and solely on account of the fancied resemblance between one of the gross lesions of that pathological condition and a lesion that may have been produced in provings or poisonings with the given drug.

Wherever it is possible to supply additional data of an individualizing or characteristic sort that should be done. I believe that the symptoms and phenomena presented by most of these cases more nearly resembled the symptoms recorded in the pathogenesis of Atropine Sulph. than any other drug. Especially was this the case when I was fortunate to have seen the patient early in the attack for which I was prescribing. These symptoms are quite well recorded, and may be consulted in toto by any one who so desires. I may perhaps as well refer to the more striking ones here, for I have never

witnessed more prompt relief and satisfactory effects than in those cases for whom the Atropine Sulph. in the 3x trituration was prescribed.

The patient immediately throws up all that has been swallowed. It does not taste sour or unpleasant; is as it was swallowed. Immediately after vomiting is relieved of all distress, as a rule. The vomiting was not, as a rule, attended by much nausea, nor retching. The vomiting came on immediately after an increase of the Epigastric pain. Appetite good, but as soon as eats anything there occur eructations and vomiting.

The pain in the Epigastrium is likened to knives, cutting, shooting or pinching; is worse after eating, and followed by vomiting of food as taken with relief.

Occasionally the vomited matters were so sour they set the teeth on edge.

The patient is nervous, sensitive and easily startled.

The tongue not badly coated; may be red or dry looking.

Cold hands and feet; some headache and heat of head.

There is marked sensitiveness in the region of the stomach, particularly in one spot, which is between the ensiform and the umbilicus.

I suppose of all the remedies that have been used in gastric ulcer the *Argentum Nitricum* has been oftenest prescribed by the practitioners of our school. Yet in the cases that have come under my observation it is a remedy that has only occasionally been serviceable. There are reasons for this. The gastric symptoms of the Argentum are usually accompanied by very prominent belching, or eructation. The occurrence of great distension of the stomach, followed by forcible and loud eructations, therefore would doubtless attract attention towards this remedy. So also would the distinct radiation of the gastric pains in various directions, under the heart, to the back, or under the left scapula. These symptoms, accompanied or followed by a pain that could best be described by the patient as a deep *gnawing*, as from ulceration, and the marked sensitiveness to pressure somewhere between the sternal notch and the umbilicus would also be suggestive. I think, perhaps, in this remedy the pain might be worse an hour after food rather than immediately after, and this would be followed by really violent efforts at retching and vomiting. Now it so happened that only occasionally have I been able to recognize clearly the Argentum picture in my cases of gastric ulcer. There is, too, a word of caution that should always be mentioned when this

remedy is recommended to another. Never buy it from the pharmacist, unless he will prepare it freshly for you, but rather make its dilutions for yourself, in distilled water in the usual manner. The sixth dilution so prepared and administered is quite a differently acting remedy from the old tablets or dilutions sometimes obtained in the shops.

Arsenicum Album has been of splendid service in the treatment of several cases. It would be presumptious to repeat the well-known symptoms and complaints for which this remedy was selected. Its action is very prompt. I would not limit my use of this remedy in gastric ulcer to the favorite 3x trituration so commonly prescribed.

And likewise I must refer to the fact that *Phosphorus* is a very dependable remedy in gastric ulcer when prescribed for the tram of clinical phenomena which that drug cures for us daily. I would not be averse to giving Phosphorus in the higher dilutions in these cases.

Hydrastis Canadensis seemed in two cases to be exactly what was needed medicinally. Attention was directed towards this remedy by the occurrence of symptoms indicative of the weak atonic state so characteristic of the Hydrastis, the patient complaining of "her stomach feeling so distressingly weak, and empty at times," and also being annoyed and even terrified by "beating or pulsation in the epigastrium," and the additional fact that she could retain nothing save milk. I suppose that, taking a strictly pathological view of such complaints as these, they are not very important. But if they but *start* the therapeutist upon a further comparison of Hydrastis they must be of great value.

These were about all the remedies that were required in the cases now under consideration with the exception of *Kreosote*. I must thank this remedy for the relief which it has many times afforded, particularly to the almost incessant nausea and vomiting. Strange to say, it has seemed to be a clinical fact that the 30th dilution was most effective. I make this statement after a thorough trial of other dilutions below the 30.

I am convinced after many disappointments that the only satisfactory way to select the remedy for a case of gastric ulcer, or in fact any gastric ailment, is by the laborious method of culling from the mass of clinical phenomena those symptoms which are striking, peculiar or characteristic of the case under consideration and selecting the remedy more particularly for these. It seems impossible to win success here for any easier generalizing method.

But while, as we have said, it seems indispensable that we should carefully individualize our cases when we are selecting the medicinal part of the treatment, one will quickly admit after a little experience that in another direction, there is a very important place for generalization in the treatment of our cases of gastric ulcer. So important is the question of rest and feeding in this disease that one is justified in saying that it is *always* a dangerous proceeding to attempt to treat a case of gastric ulcer, even for a short time, with the patient upon his or her feet, and upon simply a restricted dietary. An ulcer of the stomach, no matter how small, demands complete rest and immunity from the irritation that would be occasioned by the ingestion of even light food. And a patient with a gastric ulcer needs liberal feeding, but not by the mouth in the ordinary way. Such a patient, I may say, is always poorly nourished and anaemic. He must be built up or the ulcer will be slow in healing. Therefore, here we may generalize to our heart's content, and say that *all* such patients require, first, rest in bed, and second, systematic feeding per rectum.

How long this general treatment must be kept will differ in different cases, yet it must never be for too short a period; rather let us err in the other direction.

I should like to know how many of the so-called relapses of gastric ulcer cases are due to the "relapse tendency" of the affection, and how many are due to the fact that too short a period has been allowed for the ulceration to have healed properly and completely; so that a resumption of solid food and ordinary habits of life quickly determines a recurrence of the ulceration. It seems desirable, in a case of the ordinary type, that the process of feeding by nutritive enemas exclusively should continue for at least one week. Then if all goes well, and the vomiting has ceased, the sensitiveness has disappeared entirely, and the patient claims to be very hungry, we may supplement the rectal feeding by careful mouth feeding for another week or two. As the patient takes more and more per oram without distress, he may take less and less per rectum, always providing that the physical condition will warrant a reduction of the amount of nutritive material introduced into the system through the rectum. It is better in these cases to aim at building them up by your feeding processes rather than to aim at simply keeping the patient alive, for I am sure an ulcer heals more kindly in a well-nourished invalid that in a cachectic and poorly-nourished one.

I am also certain that we should keep our patient in bed for some time after he or she claims to be able and willing to arise. Allow

them to recline in a sitting posture in bed, if you must; give them massage and passive movements of a simple sort if you will, bathe them regularly, of course, but do not permit them to arise from their beds until a month or two or even three shall have elapsed. If you will do this, you will not be sorry. It should take as long to cure a case of gastric ulceration as it does to cure the intestinal ulceration due to typhoid fever, if not longer, because the process in the former is not so acute as in the latter, and therefore heals more slowly. My object in saying this is to discountenance the plan of curing these cases in about two weeks. One week rectal feeding, one week restricted diet, then discharge the patient. It is likely that a case so treated will relapse, within a few months at least, if not sooner.

DISCUSSION.

Dr. Anna C. Clarke: I was particularly interested in this case, for I had a number of similar cases recently, one particularly in an institution, where the girl, about eighteen, had had malaria last year and had another attack this summer, and while I was on my vacation she was sent to the hospital with what appeared to be typhoid fever. She was there a few days and came back well, but I questioned what she ate. She had been home about two or three days, when I received a telephone saying this girl was vomiting blood, and in large quantities. I found that, in all probability, she had gastric ulcer, and I immediately stopped all food as she had been trying to take it and gave her absolute rest, and from her general history concluded that Hydrastis was the best remedy, and began to give it. She only had one attack of vomiting blood after that. We gave nutrition per rectum and used cocoa butter inunctions twice daily. The patient is still in bed; but she wants to get up, and we think we will get her well. She is well nourished and is beginning to take milk per stomach; complains of being hungry when it is time for her to be; she is not thirsty. She had very little pain and it is all gone.

Dr. W. J. Martin: I wish to express my appreciation of the paper and to say that it is worth all that it has taken to come to Wilkes-Barre to attend your meeting here and listen to it.

I do not recall treating many cases of gastric ulcer. There was one case last winter, in the hospital service, that got well under absolute rest treatment and Argentum Nitricum and rectal alimentation. I

would rather treat such cases in the hospital than at home; in the hospital they will carry out the instructions given them.

Dr. J. L. Peck: Speaking of inflammatory infiltration, I saw a case three months ago with one of the physicians in Scranton, and we found a decided tumefaction in the region of the pylorus and duodenum. It gave a great deal of pain and stiffness, and the woman, who was thirty-nine years of age, was somewhat emaciated and anæmic. I was called in to give an opinion as to whether it was a proper case for operation, but I thought that her physical condition was so low that it would not permit of operative interference; she had symptoms that were somewhat of the nature of cancer, although she seemed a very young woman for that malady. The vomit was of a coffee ground nature of very dark blood, and shortly after that I was present at the autopsy and we found the pylorus and duodenum greatly thickened, greatly infiltrated, in that the lumen of the valve was almost entirely obstructed. She had symptoms of cancer or inflammatory infiltration there and obstruction of the bowel, with the characteristic symptoms of obstruction; she was on rectal nourishment at that time. The woman died from exhaustion and not from hæmorrhage.

I am rather inclined to think that this was a case of ulcer rather than cancer, on acount of the age of the patient and the precise nature of the infiltration surrounding the disease. There was a punched-out ulcer in which you could put your finger which had almost eaten its way through this thickened portion. There was also a round, penetrating ulcer, but it had not penetrated the pylorus.

I bring this case up to show the extensive infiltration that may go on if not recognized early and put on proper treatment and rectal nourishment.

Dr. O. S. Haines: I am afraid I did not make one point quite clear: How long a chronic gastric ulcer may last with almost classical symptoms and yet the patient be about? I mentioned one case which had lasted seven years.

I was in hopes that some members of this Section would have something to say about the best nutritive materials and fluids that should be used. I have had some very curious experiences. I have seen almost every fluid thrown into the human rectum and not come back, and I have come to the conclusion that the absorptive powers of the mucous membrane of the human rectum are wonderful. Two or three days ago I saw a doctor use an egg-nogg—two eggs and

brandy. We have been told that the yellow of egg is not absorptive. I do not believe it; I believe that it is. I questioned the nurse and she said: "Nothing came away." The rectum likes egg-nogg. So that I have come to place great confidence in the absorptive powers of the stomach.

I had hoped that some one would speak of his experiences with the best alimentary substances to use in these rectal enemas.

WHAT WOULD HAHNEMANN DO IF HE WAS HERE?

O. H. PAXSON, M. D., PHILADELPHIA.

THIS interrogation of itself implies that there is at the present time this question in our minds, whether there is not a departure from the practice of medicine according to the principles of Hahnemann.

It is an honest question that each of us should be willing to ask of ourselves, whether we are following in the footsteps of our honored and beloved master. What and where are his footsteps and whence do they lead? They began one hundred and forty-five years ago when he was born, on the tenth of April, 1755.

You all are familiar with the history of the difficulties and struggles he passed through to gain an education. How he had to overcome the opposition of his father to his studying, and who wished him to follow some other occupation more suitable to his, the father's, means, and also the difficulty of supporting himself and paying his teachers. His intense love of study and his indomitable will overcame all opposition.

At twenty years of age he began the study of medicine, a time of life when many of you gentlemen began as he did; but under what different circumstances. You had parents and friends to encourage and urge you on in your work; you had the advantage of a well-equipped college and enthusiastic teachers. With Hahnemann how different.

With him it was a life of denial and struggle for existence as well as for study. For two years he taught and attended lectures in Leipzic, after which he went to Vienna in order to study practical medicine by attending the hospital of the Brothers of Charity, with Quarin. In 1779, after four years of work and study, he received his degree of doctor of medicine.

After your graduation you most earnestly and anxiously sought a location where you would be welcome and where, if successful, you would hope to remain for many years, and in this you older members have succeeded and are honored and loved in the cities of your adoption, and I hope the younger members may be as fortunate in their selection. With Hahnemann we might say "like unto a rolling stone." From Erlangen, where he received his degree, in 1779, to Hettstadt and then to Dessau. In 1781 he was in Gommern and then to Dresden. In 1789 in Leipzic, in 1792 in Gotha. He spent some time in Molschleben, near Gotha, and in 1794 went to Pyrmont, remaining there, however, but a short time, and then to Brunswick. In 1797 at Konigslutter. In 1799 he went to Altona and Hamburg. From there to Eilenburg, where he had some difficulty with the municipal medical authority because he insisted on dispensing his own medicines.

On this account he again took to his wanderings and went to Machern, near Leipzic. From there to Wittenberg and then back again to Dessau, where he remained two years. In 1806, in Torgau, he wrote his Organon. Again in Leipzic in 1811, to qualify himself at the University there, so as to be able to give lectures on his new system of treatment. His practice of dispensing his own medicines alarmed the apothecaries, and in the proceedings against him he was forbidden to dispense his own medicines, which made it impossible for him to practice there. In 1821 he went to Cothen with full liberty to practice as he chose. In forty-two years he changed his residence nineteen times, and at the age of sixty-two began, what we might call, his permanent residence in Cothen, where he remained for fourteen years, until he removed to Paris.

There can be no questioning that Hahnemann in the latter part of his life, if not in the first part, practiced what all men would consider as the true standard of Homeopathy, and it is certainly logical to believe, that if he was still living today, his methods would be our standard. Is the principle of homœopathy as given to us by Samuel Hahnemann, nearly one hundred years ago, sufficient for all time, or is it limited to the period of his life?

Does his principle of homœopathy, as published in the Organon, permit of the wonderful discoveries in the field of medicine since his time being used by a homœopath of today?

Is the practice of homœopathy, pure and simple, practicable in the light of the knowledge we possess at this present time?

Is homœopathy a living issue, or is it a dead and barren principle as some of our contemporaries would have us believe?

These are important questions for us to consider and then for us to act upon. I would affirm them all. In his footsteps we would find the same answer.

Expansion is the burning word of this day. Expansion of the Nation and its territory is the great political question of this age and generation; expansion or extension of the creed is one of the foremost and most important discussions agitating the religious world of today. So it is in the field of medicine, and I believe that even a Homœopath has a right to expand. Hahnemann was an expansionist. He was not content to accept the teachings and practice of his predecessors, but demanded and obtained the right to practice the art of healing the sick according to a new law which he had discovered.

There can be no disputing of the fact that Hahnemann was successful in his work, both from a financial standpoint, and especially so in that which every true physician desires to excel in, the curing of the sick. It was practicable in his day to be a successful homœopathic physician, and it is so at the present time.

If, then, this be accepted as a fact, we may ask this question, why should we depart from following in his footsteps?

Not because of any change in our medicaments, for we surely believe that the chemists and pharmacists now are as skillful, nay more so, if it were possible, than in Hahnemann's time. Neither is it because of any marked change in the forms of disease which we have to combat—the foe and the weapons are as of old, the same.

Bear it in mind that we have all that Hahnemann had in his fight with our common enemy—disease—we have even more, the benefit of his experience and his example, and of all the discoveries since his time. There have been many additions to the armamentarium of the physician, and therein, it is believed by many, lies our stumbling block, as it is as to our use of these so-called discoveries that we are held to be true or false to our principles.

One *definition* of a homœopathic physician, and I need not inform you who would supply it, is first: an individual who has a right to acquire and possess all of the knowledge that the learned Hahnemann bequeathed to his successors—no more, no less; second, he is *not* to investigate nor is he to study diseases in *any other manner* than was known to Hahnemann; third, he is *not* to *use* or to *prescribe any* palliative drug nor so-called cures, even to prove their

lack of virtue; fourth, he shall have *no right* to an opinion as to the merits or lack of merit of a remedy prescribed by one *other* than of his own school; fifth, it is even questionable whether he has a right to practice a *specialty;* and finally, if he prescribes remedies selected homœopathically, he is a fool, if he does not and uses a remedy otherwise selected, he is a knave.

Do not be dismayed by criticism, rather glory in it. It would be better if we had more of the right kind. Mills says: "We often hear the teachers of all creeds lamenting the difficulty of keeping up in the minds of believers a lively apprehension of the truth which they nominally recognize, so that it may penetrate the feelings and acquire a real mastery over the conduct. No such difficulty is complained of while the creed is still fighting for its existence. Beware of deep slumber of a decided opinion."

Have you any doubt that if tomorrow, by the passing of certain laws, we were to be restricted in our right to practice the art of healing the sick according to our present belief that there would be such forceful arguments and proof brought to bear upon our opponents that many who believed otherwise would be converted to our way of thinking. Would you, with all the shortcomings known to exist in the practice of homœopathy, be willing to part with it in whole or in part? We claim for homœopathy that it is not a dead principle, but that it is a living truth. That we are following in the footsteps of our great master, some with greater enthusiasm than others.

DISCUSSION.

Dr. R. E. Tomlin: I hoped that I would hear a good deal of discussion on this paper. I think there are enough men here to defend our rights. I personally do not think any man present feels that he is so bound that he cannot use any remedy or any means that he has good and sufficient reasons for believing will benefit his case. A man who is simply educated, solely and only in homœopathic therapeutics, may be a very good prescriber according to homœopathic laws and rules, but there are so many other things that enter into our practice. There are many times when we need other means, while there are other times when chemical and mechanical conditions exist where possibly surgical conditions exist. And should not a homœopath know anything of surgery or gynæcology or anything of the other specialties? Why, it is an evidence on the part of some of our critics

of their illiberal spirit! They do not know our law. They do not know the need and working of it.

It has been my custom for a number of years to attend the Pennsylvania Hospital in Philadelphia whenever possible, and I have frequently seen the eminent Prof. DaCosta—many of you, some of you present this afternoon, have seen him bring in a case of heart disease. He said: "Gentlemen, digitalis is the remedy. We will give it in such and such a dose." At the next clinic a heart would be brought in on a plate, and he would say: "Gentlemen, too much digitalis." I tell you that is a pretty serious joke if it is applied to you or me. I think we should have a little more backbone and should not be ashamed of the condition in a typhoid case—wash out the colon and rectum and use the normal salt solution, as was done in Dr. Beale's case. He used it, and we should know it.

THE PREVENTION OF PULMONARY TUBERCULOSIS.

EDWARD R. SNADER, M. D., PHILADELPHIA.

THE prevention of pulmonary tuberculosis begins, or should begin, in the spermatozoa of the grandfather or the fecundating element of the grandmother. To prevent disease by the control of hereditary influence is a method so ideal that we can never even hope to be able to dominate this causal element. No set of laws could be framed that could by any possibility of means specifically and positively control this one factor, and if rigid laws were framed they would never be enforced. Fortunately, according to modern medical investigation, direct heredity is a cause of pulmonary tuberculosis in only a very small proportion of cases. An enormous number are, therefore, acquired. This is particularly true, if we accept the theory of the bacillary origin of the disease. There are those among the medical profession, however, who, while giving adherence to the theory of the causative role played by the bacillus of Koch as the most credible working hypothesis extant, yet firmly believe that the soil has far more to do with the development of pulmonary tuberculosis than the seed. These observers, too, are of necessity, in view of the ideas they entertain, not pleased that the causative culpability of hereditary influence should be so summarily disposed of by the modern statistics showing that ante-natal elements are so

minimally represented as an etiological factor in the production of phthisis. They know that the soil must be made ready for the seed. They know that the soil may, if the seed cannot, be transmitted. The statistics do not deceive these broad-viewing observers. Wherever they can they prevent the marriage, not only of the already tuberculous, but of those likely to become so. If we knew with mathematical certainty what the tuberculous diathesis really is, we would certainly be in a position to do more than we now do to prevent the marriage of unsuitable persons. But just what this inscrutable something is that dominates cell life and makes a tuberculous soil no eye has yet been keen enough to see and no microscope powerful enough to reveal. Of course, we describe several constitutional states and bodily habits that we feel tolerably certain about. But what percentage of those who look typically able to develop tuberculosis on the slightest provocation actually develop the disease? Think for one moment. How many of your phthisical patients actually present these classical landmarks of the phthisical tendencies? You have, it is quite true, seen some of these characters develop *pari parsu* with the evolution of the disease, so that you sometimes wonder whether the disease itself did not develop the conditions of diathesis rather than the disease develop on the diathesis in these particular instances. Knowing so little, then, of the characteristic peculiarities of those who present the proper soil for the development of consumption, and seeing how frequently those escape who are typically entitled to do so by virtue of their constitutional habits, we are compelled to go about our prophylactic work somewhat blindly. We must be on the broadest possible kind of ground. That "broad ground" means that everyone who is at all ill must be made well, if possible. To bring about this desirable end there must be a complete change in the medical profession. We must know more about medicine in its broadest, deepest, widest sense. Every general practitioner must be more of a specialist, and every specialist must be more of a general practitioner. We must teach the public that the presence of disease does not necessarily imply that the individual is obviously ill. We must teach the laity that it is a crime for them to decide for themselves that they need or do not need treatment. When the public are thus taught, we will be able to help that vast army of patients who come to us occasionally, whom we feel certain need to be cared for medically, and yet are to the eyes of most lookers-on in perfect health. When the community individually and collectively ceases to be its own doctor, the medical profession will learn

more of the actual nature of constitutional states that precede not only the development of pulmonary phthisis, but of other malign maladies. When the eyes of both the profession and laity are opened, and the doctors are more learned and strong in the power that knowledge gives them, all the medical text-books will have to be rewritten. How much we would all give if we could express to each other in intelligible fashion the "something" we know about disease that have never been written in any book, nor told us, but has simply come to us from our constant contact with illness. A look, a touch, a gleam of the eye, an odor, a movement, or a something inscrutable, sometimes sheds a flood of light upon the condition of the patient. We often know that patients under our care occasionally, or perhaps permanently, are not well, but for the life of us we cannot make their cases fit into any text-book description of disease, or diathesis, or cachexia. We must know more, and then perhaps we will be able to theorize, formulate and precisionize more than now. Every ill person, then, should be under the doctor's care until well, and all should be held under suspicion. This is idealism, I know. But, pray, how much prophylaxis have we had from practicalism, so far as hereditary soil-making or soil-immunity prevention is concerned?

The next phase of the subject that naturally presents itself for consideration is the isolation of those suffering from phthisis pulmonalis, in order to prevent those who have not the disease from acquiring it. It must be frankly admitted, if properly analyzed, that the isolation theory is a brutally selfish one, that would be enforced for the protection of the well against the ill, rather than with anything more than a faint hope that in some inscrutable way some poor devil might recover. The isolation of sufferers naturally implies that the cases shall be discovered; but, in order to be discovered, they must be diagnosed, and then reported. Reported to whom? Why, the health authorities, you say. What health authorities? Those only in one, or at best two, of the larger cities of the Union. Any effort to be successful would have to be practically universal, and consequently at the very outset of the work of isolation there would have to be an inauguration of a series of municipal, borough, township, hamlet and country-side laws to assist us in securing this desired isolation. Before this could be done the general public would have to be educated up to an appreciation of the gravity of the situation; and it is reasonable to suppose, if we take into consideration the time it usually requires for a sanitary notion to take root and grow in the cerebral cortex of the average layman, and then multiply that

by several million, that it would not be an estimate drawing too largely on the imagination to say that the medical millennium will have come and gone before this creation of a proper sentiment in communities could be accomplished. There is only one way out of this difficulty, and that would be for the doctors to make the health laws, which Heaven forefend! We are by no means united, and the advancements of science and knowledge compel us to alter our front in the most chameleon-like fashion. We are never long united; and even the very idea of isolation, or rather the suggestion of its utility, is a legitimate offspring of the germ theory of the origin of pulmonary tuberculosis. There are several missing links that must be discovered and demonstrated before even the majority of physicians will accept the theory in any other light than that of a simple working hypothesis, whose reason for existence may pass away day after tomorrow and be superseded by another more fascinating or convincing theory. Admit, however, that isolation is right, and that it could be fairly well carried out, that isolation must of necessity be preceded by a diagnosis of the disease for which the sufferer is to be isolated. Just here is the rub. I shall now make a statement that may seem dramatic and startling. My experience as a physical diagnostician teaches me this point: Eight-tenths of practicing physicians do not know how to diagnose phthisis pulmonalis. The vast majority of consumptive patients do not arouse even a suspicion of the nature of their malady until the red flush of hectic has planted its crimson signal of "no surrender" upon the malar eminences. Until this disastrous period has arrived, then, these patients for one, two, three or four years have been spreading infection, atomizing the surrounding air with bacilli, spores, ptomaines, staphylococcal and steptococcal pus with every cough. Isolation, to be of great practical service, must be begun at the earliest possible period. As a step in the forward movement we will have to reform our ranks, so that the disease may be recognized at a safe period. That innovation will be indeed a most valuable and practical contribution of the medical profession to the cause of the healing and humanity. But suppose we can diagnose the disease in the earliest infancy of its onset, when shall we isolate and whom shall we isolate?

That "whom" and "when" is another rub. If you will think for a second seriously, you will come to the conclusion that there is not one family in a thousand who, either in its direct or collateral branches, has not lost one or more members from the fell destroyer,

the "white death." If we believe in this idea of isolation with the firmness of the Cæsar who sacrificed his son to the principles of right, we shall have to tear a babe from its mother's arms, a wife from her husband, a husband from his wife, a child from its parents, ruthlessly and unflinchingly, mercilessly, brutally, and sometimes, too, at a period when the sufferer is not an invalid, and has possibly years of useful or fairly useful life before him or her. Is a consumptive a virtual leper? If so, at what period of time does he become so? When, if ever, does he cease to be so? If it were an arbitrarily fixed and unchangeable law that all tuberculous patients must be isolated as soon as discovered, before you would issue a fatal sentence of expatriation from all that make life tolerable and happy, and places the patient where he or she may be made worse by concentrated infection, think a good while and hope more. You would think of certain dead-house revelations. How many patients have you seen on the post-mortem table and in the dissecting-room with the healed lesions of phthisis pulmonalis? What a revelation! Consumption of the lungs, then, does recover spontaneously sometimes? and probably in many more cases than die from the disease. What an affront this is to the awful pessimism that exists in the medical profession about the curability of phthisis pulmonalis. If nature can cure, why not art? We certainly, if we have any right whatever to an existence as a professional body, have helped nature before in other diseases, why not in this one? You may say to yourself that this course of reasoning is all sophistry, born of sympathy; and you are right; but just as surely as your sympathies are touched by a victim in your own family or in one of your beloved families (or possibly in any of your families), these sympathetic sophistries, as you may please to term them, will come to your minds, and you will be as human as you have often been before when the boards of health have stood between you and your patients.

You will be enforced in your disobedience against law, too, perhaps, by reasoning that law is made for the majority, and not for the individual, particularly for your individual. You will, in imagination, see some poor, condemned consumptive shake his feeble fist at you, saying: "You have condemned me to exile to protect yourself. You think you are safe, now that I have been stamped as a leper and unfit for human society. You are but an atom safer than before, for there are tens of thousands like me who are pouring forth poison till it invests you all as an invisible cloud. When you condemn me

you should find all and should condemn all. You think you can stamp my disease out by stamping me out. You cannot kill all the germs of my disease any more than you can those of other diseases that are as bad or worse than mine. Learn to cure the disease. If I must go, send all those with me who have ever come in contact with me since I had the disease. Hound them all out, whether sick or well. My contribution to the possibility of spreading consumption is only as a little mote in a sunbeam. Remember, that equal justice demands that I shall be protected just as much as you are. Send away with me the sufferers from tubercular synovitis, fistula in ano, Potts' disease of the spine, tubercular disease of the bones, testes, ovaries, bladder, kidneys, liver, pleura, and the meningeal cases, if they last long enough. Be sure to send all the questionable glandular hypertrophies along. Find everything that bears the slightest resemblance to tuberculosis, developed or undeveloped, and all you suspect are liable to develop it, and deport them too. By that time your population will be so decidedly thinned out that the number of germs remaining (for you cannot by any possibility of means dream of destroying them all) will be so many for the extent of population that you will all soon pass away in death in your 'protected' communities. We poor wrecks and lepers will outlive you all."

This may be called a fanciful picture, I know; but just the same it stands to reason that a law to be effective must be universal in its application, and to be operative must be enforced, and the law would not and could not be universally enforced. You would individualize, and while you are a doctor and a scientist, you are also a man and human. Besides, laws were made for man, not man for the law.

If, then, it seems next to impossible to do anything more than limitedly control the development of pulmonary tuberculosis, from an hereditary standpoint, and for the many reasons stated, to make the principle of isolation practically applicable only to a minimal extent, it follows that our greatest hope of preventing the development and spread of tuberculosis must be in the care of the individual, and through him of the community, aside from the manifest benefit derivable from hygiene, disinfection, and personal and care-taken sanitation, must be in the way of making the soil unsuitable for the seed, for the seed we have always with us, and always will have. But, you cannot grow a rose on a rock, and if you have no soil you will have no tuberculosis, no matter if the air swarms with the micro-organic

cause. We are not certain of the special kind of soil that the bacillus of Koch loves, and therefore we must assume that all ill-health predisposes, more or less, to the disease. We know, too, that the soil does change by natural means, for we have seen the dead-house revelations of cured phthisis. There can be no doubt whatever that much can be done to alter the soil that predisposes to phthisis. While medicines will doubtless be of great service in this work, proper food, light, air, sunshine, rest, exercise, and the observance of the laws of personal sanitation, must be at the very foundation of any rational attempt at a prophylaxis against this dire disease.

This proposition by no means implies that we are to relax by one iota all just, legitimate and practicable methods of germ-killing and the prevention of infection, for we cannot hope to correct all soils any more than we can hope to destroy all germs and their products. Very often these preventive measures are one and the same with the soil-correcting means. Often both methods will pull in harness together as yokemates in the good work.

This scheme of prevention will require an enormous amount of work on the part of the doctor, the nurse, the layman and the governmental authorities.

We must teach the housekeeper that dust is an abomination of abominations in a sanitary sense; that a wet cloth is the superior of a broom; that rooms unaired are breeding-places for germs; that ventilation is as important as proper heat; that good food, properly prepared, is essential to health; that rugs are better than carpets; that heavy hangings at the windows are harboring-places of infection; that the condition of the water-closet is of more meaning from a sanitary outlook than the appearance of the parlor; that sunshine and fresh air are life-principles; that the bath-room is a place where devotions are offered at the shrine of personal hygiene, and that, if "cleanliness is next to godliness," they can get there every day cheaply and pleasantly; that the home is a man's castle; and that it ought to be protected from the germ-enemies that are far more malign than any human foe.

We must teach employers that the health of their employes is as precious to the humble toiler as to the rich; that where much dust is of necessity disengaged and kept floating in the air, the employes should be made to wear respiratory protectors over their mouths while at work; that the rooms must be ventilated; that extremely young persons should not be given employment; that holidays increase the working capacity and healthfulness of the employed; that

good drinking-water and other sanitary necessities be attended to; and that they can get some pointers from the housekeeper that will make them philanthropists of the first water.

The government must take care of the indigent sufferer from phthisis, both on the grounds of humanity and sanitation, either isolated from other poor patients or not; they must make and enforce laws against milk and food contamination, and provide for the inspection of every product sold in the public markets that are known to, or can be suspected of, harboring deleterious germs; they must institute competent inquiry into everything from a sanitary or food standpoint that will in any way whatever assist in the better prophylaxis of disease; they must give protection to the physician in the carrying out of sanitary instructions, and at the same time give him the largest possible field for the exercise of individual judgment; that they must prevent the discharge of patients from sanitariums as cured when they still have bacilli in their sputa (*i. e.,* when the germ theory has been proven to be indubitably correct, but not till then).

The parent must be taught that a head crammed full of information at the expense of long hours in the school room is paying very dear for a whistle; that a Brobdingnagian head on a Liliputian body is a gold-cornered invitation to phthisis; that exercise in the open air is of more importance than the rule of three; and that the municipality that orders physical exercise given to girls or boys indiscriminately without a request from the family doctor is a prey to the machinations of some crank on physical culture whose instructions, if followed out without individualization, will indirectly kill ten where it helps one; that much home study is likely to lower the vitality at a time when the strength is needed to build a body fit for the mind and soul to live in; that an education, so-called, that attempts to train the mind at the expense of the body is saving at the spigot and wasting at the bung-hole policy, and leaves the student a fit subject for any disease, consumption included; that the school-rooms and appointments must be in the highest degree sanitary; that the lunches in the school-room should be forbidden; that the Italian vender of hokey-pokey and pretzels, with his dust-covered wares, should not be patronized; that an easily-erect attitude be insisted upon at desk; that the time for recess should be extended and the actual period in the school-room shortened; that so long as the doctor is not satisfied with the physical condition of the children they should re-

main in the physician's care, whether in or out of school; that colds are dangerous; that bronchitis is not a simple disease.

Nurses, lay or professional, must be taught that the presence of dirt of any kind is a venial sin, but that neglect of the rules of sepsis and antisepsis is a crime for which there is no pardon; that a "stuffy" room is a disgrace, and that fresh air and sunshine in a sick-room are essentials; that their own health requires a daily outing; that to fail to remove discharges of any kind, sputa included, endangers everybody and themselves; that a room atomized by pus and other germs and spores may be very dangerous, although it smells sweet.

Both doctors and the laity must learn that lung quiescence predisposes to phthisis; that properly executed breathing exercises are as essential to bodily health as the morning prayer is to the moral strength, and that all stoop or round-shoulders be prevented or corrected; that so-called athletics are a delusion and a snare, and directly lay the foundation of disease (and especially phthisis) by destroying the health-trinity of a sound mind, a sound body, a sound soul, by over-developing the muscles at the expense of the nervous system, thus deranging the balance in the trinity; that exercises should never go beyond the plane of slightly stimulating the normal functions; that the undue consumption of food predisposes to phthisis by overworking the body's sewers to eliminate waste; that improper drinking of alcoholics predisposes not only to phthisis, but to other affections nearly as bad, but for which the law will not attempt their isolation; that sunshine in the living-room by day and air night and day are the first two commandments of the gospel of health, and that temperance in all things is the third, cleanliness the fourth, and that there are more than ten of these commandments, some private, particular and individual, that only you would know about, that must not be violated.

Physicians *particularly* must learn that any lesion anywhere in the respiratory tract, from the nasal entrances down to the air-cells, must be corrected, even if it be only a so-called simple catarrh or a few adenoids; that mouth breathing is a sin in a sanitary sense; that bronchitis often lays the foundation of phthisis; and that bronchial inflammation should not be considered cured because the patient no longer coughs, but that the condition of the bronchial mucous membrane sends out an invitation to any disease, but consumption of the lungs preferably, just so long as the membrane is unduly moist; that the doctor will tell the patient when he is well of a bronchial inflammation, and not the patient tell the doctor; that all pulmonary dis-

eases, whatsoever their nature, should be screened from possible contact with the tubercle bacilli; that you will not treat a case of croupous pneumonia in the hospital in a cot next to a sufferer from phthisis unless you want to produce a case of mixed infection that will terminate fatally, in the interest of science; that all blood diseases send much of their contamination to the lungs, and hence predisposes the patients to phthisis by lowering the vitality of the pulmonary tissues; that rheumatism and its consequent endocarditis is to be guarded against, for acquired valvular disease of the heart, by causing pulmonary backwash, directly predisposes to phthisis; that diseases of the liver, by loading up with waste, predispose to consumption; that intestinal auto-infection, so-called dyspepsia, anæmia, constipation, deficient kidney elimination, all are soil-producing factors that may, neglected, produce phthisis; that all the constitutional diseases are seed-inviters, and that measles, whooping-cough, typhoid fever, bronchitis, la grippe, and any of the pneumonias bear a specially close relation to the development of phthisis, both by soil-making and seed-inviting properties.

If you have followed me closely in the consideration of this subject, gentlemen, you will have perceived that I do not regard the medical profession as being as yet in a position to decide upon absolutely the best means to be pursued in preventing pulmonary tuberculosis. I believe, however, that we are able to affirm that in some instances, and along some lines, we shall be able to accomplish a not insignificant work in the prevention of phthisis. To cure, however, is the ideal, and that will be the greatest kind of prophylaxis. But in order to cure we must diagnose the disease early.

Prevention of the "white death," I am sure, will never be practically accomplished through any one channel, but only by making a multiplicity of influences tend toward the same end.

CANCER OF THE ALIMENTARY TRACT

R. E. TOMLIN, M. D., PHILADELPHIA.

When considering how I might present a paper that would prove not only entertaining, but clinically helpful, to the great body of practitioners, I thought of a case under my care that presented several interesting features, and was led to prepare this article.

Before reviewing the case, however, a glance at the latest thought of the subject of cancer in general can but prove of real value to all.

In an article, entitled "Some Thoughts and Figures Concerning Cancer," by J. R. Bibighaus, and read before the August meeting of the Twenty-third Ward Homœopathic Medical Society, he cited the fact that Dr. P. S. Hall, Professor of Pathology at Hahnemann College, in his opening address on tumors, remarked that the subject of tumors was the most neglected branch of pathology. He also referred to the fact that the latest text-books on Pathology, Surgery and Practice of Medicine give comparatively little space to this important subject. The book that treats this condition most comprehensively, and from which much of the subject matter of this essay is taken, is by "Senn," on "Pathology and Surgical Treatment of Tumors."

The subject of tumors is one of the much-neglected departments of medicine. Laboratory investigation, experimental research and clinical observations have revolutionized the etiology and pathology of inflammatory diseases during the last decade. The benefit to humanity in the saving of life and the lessening of suffering derived from these investigations and from improved practice is incalculable. When we realize the amount of suffering and the number of deaths resulting from tumors it appears somewhat strange that this vast department of pathology has received so little attention on the part of modern investigators. The old authors regarded tumors as something entirely foreign grafted upon the organism. In the closing year of the century there is as yet no better proof of the origin of tumors than the doctrine advanced by Cohnheim,* and further elab-

**Cohnheim's Doctrine.*—If a Carcinoma originates in epithelial cells, primary Carcinoma in mesoblastic tissue is impossible from a histogenetric standpoint, unless a matrix of embryonic epithelial cells has become displaced during the development of the embryo, or when epithelial cells have become buried in mesoblastic tissues after birth by injury or disease.

orated by Senn, that the essential tumor matrix may be composed of embryonic cells, the offspring of mature cells which for some reason have failed to undergo transformation into tissue of a higher type, and which remain in a latent immature state for an indefinite period of time, to become under the influence of hereditary or acquired exciting causes the essential starting point of a tumor. That tumors should have been confounded with inflammatory swellings before the essential causes of the latter were discovered and understood is not strange, but that these entirely different pathological processes should not be separated sharply at the present time is inexcusable.

A tumor is a localized increase of tissue, the product of tissue proliferation of embryonic cells of congenital or post-natal origin produced independently of microbe causes. The most important histological difference between a tumor and a swelling caused by infection consists in the fact that in the tumor the localized increase of tissue is the result of proliferation of embryonic cells (of pre- or post-natal origin), which are not utilized in the growth and development of the body, or in the repair of injured or diseased parts, constituting thus a process entirely distinct and independent of the tissues in its immediate vicinity; while inflammatory swelling results from tissue proliferation provoked by the action of pathogenic microbes or their toxines upon the pre-existing mature tissue cells.

The incipient pathological product is therefore always more localized and better defined in tumor-formation than in inflammatory affections. A benign tumor always remains local, tissue-growth being limited to the fixed primary matrix.

A malignant tumor has a similar local origin, but it gives rise to dissemination by migration of cells into the adjacent tissues or by their transportation to distant parts through the lymphatic or general circulation. A tumor never disappears except by removal or destruction. Inflammatory affections lack from the very beginning the localized character of a true tumor, and the product whether the result of an acute or chronic process is composed of tissue, which is destined to succumb sooner or later to the microbe influences which produced the inflammation. Therefore, permanency of new tissue is a strong evidence of a doubtful enlargement being a true tumor; while early, and especially acute, degenerative changes indicate an inflammatory affection.

Enlargement of the superficial veins and œdema; such common symptoms of inflammatory lesions are occasionally present in rapidly

growing malignant tumors; the nearer a malignant tumor resembles inflammation the greater is its malignancy. No transition from one type to another ever takes place.

Local irritation increases tumor-growth, and tumors require an adequate quantitive and qualitative blood supply, which in itself must contain the nutritive and chemical ingredients necessary for the growth. Benign tumors push the tissues aside or apart to make room for themselves; malignant tumors infiltrate the surrounding tissues.

Benign tumors frequently appear multiple primarily or in slow succession; malignant tumors, while primarily multiple only in exceptional cases, give rise to secondary tumors in the same region or distant parts; Carcinoma, superficial and deep, almost invariably is complicated sooner or later by regional infection through the lymphatic vessels and glands.

Sarcoma seldom gives rise to glandular infection.

Carcinoma occurs most frequently during and after middle life, and in the better class of people fully as much as in the poorer classes. The influence of traumatism cannot be denied, altho' the trauma can act only as an exciting cause.

It has not been clearly proven that cancer is contagious. A tumor is either benign or malignant; there is no connecting link between them.

The clinical conduct of a tumor is determined by the nature of the primitive matrix, the anatomical structure and physiological importance of the part or organ affected and the relations of the tumor to the part affected.

A matrix from the middle germinal layer will produce a tumor of the connective tissue type,—either a benign mesoblastic tumor or a sarcoma. A matrix of embryonic cells from the epiblast or hypoblast will give rise to either a benign epithelial tumor or a Carcinoma, according to the intrinsic capacity of the cells to produce embryonic or mature cells, and the resisting power of adjacent tissues.

The important clinical aspects of a malignant tumor are:—

1. Rapid growth.
2. Absence of limitation of the growth.
3. Local infection.
4. Regional infection.
5. General infection.
6. Frequency of recurrence after extirpation.
7. The intrinsic tendency of the tumor to destroy life.

The exemption of nonvascular tissues from metastatic Carcinoma is one of the many proofs that malignant tumors are generalized by cellular elements, and not through the agency of a virus or of microbes. Metastasis always takes place through the arteries. The symptom "pain" no longer has the diagnostic value it once had. While important, it cannot be said to be pathognomic.

The prognosis of Carcinoma is greatly influenced by the histological structure and the location of the tumor. Squamous-celled Carcinoma is a much more chronic affection than cylindrical and glandular-celled Carcinoma. The location influences the prognosis in several ways:—

1. If it is on an exposed part of the body, it is accessible to radical treatment.

2. If it is on an internal organ, it is frequently not discovered until too late for complete removal.

Every Carcinoma has a benign stage. Regional infection is always progressive and retards, and frequently prevents general infection. For the purpose of removing the zone of infiltration around carcinomatous glands, as well as with a view of removing all the connecting lymphatic channels, the radical operation for regional Carcinoma should consist in the removal by clean excision of the entire lymphatic apparatus in that locality with the surrounding connective and adipose tissue. We find patients suffering from incipient Carcinoma often averse to the use of the knife, but willing to give up their lives on the operating table in attempts to secure relief when the disease has passed beyond the limits of successful surgery. Even in such cases the surgeon has no moral right to become a legitimate executioner under any circumstances. A radical operation is contraindicated by

1. Extreme senility.

2. Extensive local infection.

3. Regional infection beyond the reach of complete removal of all infected tissues.

4. General infection.

5. The co-existence of another disease, which in itself will prove fatal in a short time.

Permanent results will follow operative treatment if the operation is performed before regional infection has occurred; on the contrary non-recurrence will be the exception, and recurrence the rule, if the primary tumor is not removed until regional infection has set in.

A radical operation is indicated in all cases in which general in-

fection has not occurred, and the primary and original tumors are of such size and extent and are so located as to enable their complete removal by an operation not immediately endangering the life of the patient and leaving a wound which can be closed by suturing, or which can be healed by a plastic operation or by skin grafting, and the patient's strength is such as to warrant the operation.

General medical treatment, together with local or external, has but a limited value. The "Mitchell and the DeClat methods," and all similar attempts to cure by setting up a reactive degeneration, comprise all those cases readily accessible to external applications. A complete description of the "Mitchell method" is found in "Gatchell's" Pocket-book of Medical Practice, p. 94; DeClat's, in Hom. Text-book of Surg., p. 1259.

The Alexander treatment for malignant growths by hypodermic medication, with a solution derived from a union of hydrocarbons and a dimethyl ketone, to which are added essential oils, gives promise of being one of the best yet discovered. It can be used in all cases, whether the growth is external or internal. It has succeeded in prolonging life in a number of cases that were doomed to speedy death. It has been used in cases of recurrence where the best surgical skill had been employed and repeated operations performed. It can be used and the patient can go about his daily business if necessary. It is equally successful in Carcinoma, or Sarcoma. It has been in use about four years by eminent physicians and surgeons. It is in no sense a quack remedy, nor is it claimed to cure all cases. Notwithstanding the claims made by some eminent Bacteriologists and Pathologists of the microbe origin of cancer, they have failed as yet to demonstrate the fact, and the serum treatment has not been successful in Carcinoma.

Special Forms.

Carcinoma of the œsophagus appears in two different pathological forms:—

1. The soft variety, which leads to early ulceration and perforation.

2. The hard form, which results in the formation of a circular stricture, and seldom involves more than one inch.

Not infrequently perforation into the trachea, posterior mediastinum, or the pleura takes place.

The first symptom to attract attention is the inability to swallow solid food.

The food is not vomited, but is regurgitated, and is ejected unchanged. As soon as the tumor interferes with deglutition marasmus very rapidly sets in and death speedily follows.

A gradually increasing stenosis of the œsophagus in persons advanced in life, in whom the clinical history does not reveal the existence of the usual causes of cicatricial stricture, is with very few exceptions indeed caused by Carcinoma.

No force should be used in passing the œsophageal bougie through the stricture. Stomach feeding through elastic tubes should be practiced where possible; otherwise Gastrotomy should be performed.

Cancer of the stomach occurs frequently between forty and sixty years of age. The usual symptoms of indigestion are the early indications, followed by irregular vomiting, pain, hæmorrhage, tumor, cachexia, etc., etc. Diagnosis depends upon presence of tumor, character of vomit, fragments of cancer tissue and cancer cells, in wash water, excess of lactic acid and absence of H C l and digestive ferments. Prognosis. If diagnosis is made before regional and general infection occurs Pylorectomy, or Gastro-enterostomy may be successfully performed and life continued for a number of years.

As a rule, however, it proves fatal in from one to two years. Careful dieting, remedies on last page of description, Arsenic, Conium, Hydras., Argent. Nitr., Thuja, Salol, Carbolic Acid, Bismuth, Nux Vom. often afford relief.

Lavage, rectal feeding and colon flushing should be considered R's., like Phenacetin and Morphia. Codeia or Heroin may be needed for severe pain.

In cancer of the intestines, the sigmoid flexure and rectum of the large intestines and the duodenum of the small intestines are most frequently involved, according to Goodno, and according to the same authority it has no well-defined symptomatology. General dyspeptic symptoms, irregularity of the bowels, a localized pain, more or less persistent and varying in intensity, together with the presence of a tumor, cachexia and the characteristic stools, form a picture not easily mistaken. The outlook for such cases is necessarily unfavorable, unless an early diagnosis can be made and a radical operation performed, when enterectomy, or an intestinal anastomosis, or a colostomy, or extirpation of the rectum may prolong life.

The best of diet and hygiene should be employed and remedies applied as indicated.

Special medicines for the relief of severe pain will be necessary,

but should be used only when well-selected medicines or intelligent surgical interference is no longer of value.

Mrs. D., aged forty; American; widow; housekeeper. Previous to illness weighed 142 pounds; in three months lost 46 pounds; was called to see her April 29. She had just came from the Episcopal Hospital, where she had been taken six weeks previously, and was there pronounced a hopeless case, as her condition had been diagnosed pulmonary and peritoneal tuberculosis. Her sputum and blood had been examined about a dozen times, and always found to contain tubercle bacilli. They had been preparing her for a week or more for an exploratory laparotomy, as the doctors had informed her that her condition was critical and operation alone would benefit. This so alarmed her that she persuaded her friends to immediately remove her from the hospital. Her condition at my first visit was serious indeed. Temperature, 104; pulse, 150; respiration, 24. A moist rattling cough, heavy mucopurulent sputum, deep malar flushes, weak, tremulous voice and most pronounced general prostration. Physical examination revealed cavities in right lung and consolidation of left apex and spots of consolidation through centre of left lung, together with a hypostatic pneumonia of right base posteriorly. In the abdomen were discovered two masses, one in the epigastric region and another in the left iliac region, which were somewhat sensitive, and at times the seat of violent, paroxysmal pains, worse at night, especially after midnight; bowels irregular and stools or flatus fetid. No movement of bowel without a purgative, and that with small, flat and fœcal masses in it. The stomach was exceedingly irritable; vomiting everything she ate or drank; thirsty, but great pain if she drank anything; very restless and distressed. On the table at her side were large capsules containing Kreosote, which were given to her at the hospital, and after taking which she suffered intense pain until she vomited them.

In view of the above description of her case I gave a gloomy prognosis. In fact it did not seem as if the woman could live but a few days at most. Arsenicum 6x in water was prescribed.

The woman improved steadily for several weeks, so that her stomach and chest symptoms were apparently well under control.

When she had been under my care about three weeks she called my attention to some pelvic symptoms, such as distressing tenderness in both ovarian regions, with dull, aching pains extending to the inguinal regions, and which were always worse a few days before the flux, and somewhat better when the flux became fully establish-

ed. Leucorrhœa irritating and somewhat offensive. A vaginal examination disclosed an enlarged and eroded cervix. Bimanual examination revealed the left ovary distended and right ovary more firm and sensitive. Also, the growth in left iliac region above the left ovary was readily palpated on deep pressure. Under the usual local treatment of Boro-glyceride and the compound tincture of Iodine and Glycerine healing of the cervix took place satisfactorily, the woman always feeling better generally after each local treatment.

Notwithstanding the apparent success in alleviating some of her sufferings she continued to have acute exacerbations every few days, so that after being under my care a month she demanded that I open her abdomen and remove everything diseased. I stated fully and frankly the very grave conditions present and the almost hopeless outlook. No matter how I advised she insisted on a laparotomy being performed at once, and in the home of a friend, even refusing to go to any hospital. So I had the room and other necessary preparations made, and with Dr. Eberhard as first assistant and Dr. Robert Summers, a skilled anæsthetist, and a trained nurse we proceeded. The abdominal wall was quickly incised and the peritoneal cavity entered. Much to our surprise no adhesions anywhere were discovered. The large growth in the left inguinal region was found to be intimately associated with the sigmoid flexure extending to the rectum. It measured 4½x3½x2½ to ¾. It was found to be firm and resistant to touch, and yet easily lifted from its position, and to almost wholly occlude the bowel. We were of course disappointed in discovering such a condition. So we replaced it and sought for other probable diseased organs.

The liver and gall-bladder were easily palpated and nothing abnormal noted. In the duodenum, which is the largest of the small intestines and which has no mesentery, and lying as it usually does adjacent to the gall-bladder, was discovered a mass smaller in size, but similar in consistency to that which was seen and freely palpated by myself and first assistant. The ovaries were then examined. The left was found to be cystic, the right cirrhotic. As these organs had been the seat of great pain and distress, I removed both ovaries and tubes, as she had requested should they be found to be diseased. As her condition did not warrant us taking any liberties, and in view of the situation and probable nature of the growths in duodenum and sigmoid flexure, the abdominal wall was at once sutured. Union was perfect, and has remained so (four months). The pain, tenderness and great pelvic distress ceased at once, and has never returned.

The pains in the growths, excruciating as they were at times, causing even collapsic symptoms, are not so severe. The bowels still require special attention. She has seemingly improved in all ways.

However, I expect the improvement to be but temporary, as either the lung or bowel lesions may at any time precipitate a fatal issue.

The question naturally arises as to the diagnosis of the growth discovered in the duodenum and sigmoid flexure. Previous to opening the abdominal wall I did not feel certain about the diagnosis. The eminent physicians at the Episcopal Hospital, who repeatedly examined her and diagnosed the case as pulmonary and peritoneal tuberculosis, probably based their diagnosis upon the fact that, as the tubercle bacilli were always found in the sputum, a similar condition would very likely be found to exist in the abdomen. The acute gastritis from which the woman was suffering when first seen by me was probably induced by allopathic drugging, as she was taking large doses of several nauseating concoctions at that time.

It is a well-known fact that cases of tubercular peritonitis are often materially benefited by a simple exploratory laparotomy. And there are a number of cases on record where carcinomatous disease of some of the abdominal viscera has seemed to be checked in its malignant tendencies and life greatly prolonged by a similar operation.

Dr. J. M. Lee says the diagnosis of tubercular peritonitis is by no means an easy matter. After most careful and repeated examinations I felt that it could only be of the fibroid variety, as the positive presence of two large and hard masses, easily seen and palpated through the abdominal walls, and not occupying the position of any other solid organ, and the absence of fluid and other well-known symptoms, seemed to preclude any other form.

Dr. Lee also says, usually there are no symptoms which clearly indicate this disease, and that it cannot be positively diagnosed until an exploratory incision is made. He further adds that it is better not to resort to surgical treatment in the fibroid form, unless there is intestinal obstruction from cicatricial contraction of adhesive bands, or arrest of function due to imprisonment of a considerable extent of intestine. When the abdominal wall was opened no tubercles were discovered anywhere, nor adhesions of any kind. However, we found two quite firm masses involving the duodenum and sigmoid, and so far as could be discovered they were new growths. The omentum was free, as it usually is in malignant disease, until it becomes infiltrated from being attached to infected viscera, or by extension through the lymph glands. Primary Carcinoma does not affect the

omentum, as the tissue from which it springs does not exist in it, as Carcinoma is an epithalial growth of embryonic cells, the arrangement and peculiar massing together of which rather than the shapes of the cell elements being characteristic. The co-existence of tuberculosis and cancer was denied for many years, but recent observers not only admit their presence in the same person, but their existence in the same organ. The tubercular lesions prepare the soil for Carcinoma.

DISCUSSION.

Dr. O. S. Haines: The description of that change over the sigmoid flexure suggests a case I saw in Bristol two or three years ago of a little girl fifteen or sixteen, who had a very much swollen abdomen, and of whom I could never make a thorough examination of her abdominal contents on account of the ascites; she became emaciated and died. The doctor's description of that change of the sigmoid flexure was exactly what was found in her sigmoid flexure. They took it away and it was found to be undoubtedly cancer, and the absence of pain was strikingly similar. So that off-hand I see some similarity between those two cases.

Dr. T. M. Johnson: I might state that cancer and tuberculosis can exist in the same case. I have a case where I have had tuberculosis of ten years' standing in the lungs, and two years ago Dr. Hall removed a Carcinoma of the left breast. One year ago I removed the right breast, and at the present time the patient is probably suffering with cancer of the stomach.

Dr. R. E. Tomlin: I do not want to take up all your time, but I am very sorry, in the consideration of this paper, that the abdominal surgeons and gynæcologists and our experts on the chest are not present. The case has had to me a number of very important points of clinical value. In the first place, Dr. James' paper regarding the after-treatment of laparotomies would be interesting in one feature of this case, in that the trained nurse made the mistake, where she was ordered to give a teaspoonful of hot water or tea she gave four ounces, and did it repeatedly, making the mistake four or five times inside of twenty-four hours, and the patient improved by it.

That is the point in which I have personally been very much interested. Here are an equal number of eminent gynæcologists and abdominal surgeons; one set of gentlemen will say, "We don't give them anything;" another, "We give them all they can drink." Dr. Walter Strong told me the other day—and he has performed, as you

know, one thousand laparotomies—that the most successful and rapidly recovering case he had was where a woman took a large water-bottle and drank the contents, so that there is a thought there. I personally believe that in our province as physicians we get too much theory into our heads, and we lose the fact that we are dealing with human life. I have seen cases die under men whose skill I could not question. I have seen them give a few drops of water, or hot or cold tea, for three or four days, and the patient died from exhaustion, positive exhaustion. The patient is placed for three or four days on a very low diet, which may lead to gastric ulceration—a little tea, maybe a little bread crumbs or something like that, then operated under profound anæsthesia, and then nothing for three or four days to overcome shock and everything else this patient is supposed to do. It is a wonder that in many of these cases there are not more deaths.

REPORT OF THE

SECTION OF OPHTHALMOLOGY, OTOLOGY AND LARYNGOLOGY.

Digestive Ferments in the Treatment of Otorrhœa, by H. F. Schantz, M. D.
Pilocarpine in Optic Atrophy; Two Cases, by E. W. Brickley, M. D.
Eczema of the External Auditory Canal, by H. K. Hoy, M. D.

DIGESTIVE FERMENTS IN THE TREATMENT OF OTORRHŒA.

H. F. SCHANTZ, M. D., READING.

Many a physician prefers to send all his ear cases to a specialist, but he is compelled to treat his ear patients during the acute stage of the disease. Later, they may be referred to an aural specialist.

The care of ear diseases is exceedingly unsatisfactory to many, but if careful treatment is instituted early in the attack much time is gained for the patient and many an one escapes that unfortunate condition often the result of carelessness in the handling of an ear disease—deafness.

The treatment of an ear disease is difficult because of the inaccessibility of the diseased tissue. The external auditory meatus affords only a limited space for work, and the method of reaching the middle ear through the naso-pharynx and Eustachian tube is not an easy procedure. However, despite the difficulty of observation, many brilliant results have been accomplished, and the knowledge of the anatomy, physiology and pathology of the ear is becoming more complete. The general practitioner is better prepared to treat suppurative disease of the ear, and the causative relation of associated nasal disease to ear disease is more generally recognized. Many ear patients are speedily benefited by the skillful treatment of the nasal and pharyngeal conditions, and the cases of suppurative ear dis-

ease following the exanthemata are decidedly less frequent than formerly.

Suppurative Otitis Media, commonly known as Otorrhœa, or "Running Ear," is a prolific cause of deafness. It commences as a simple abscess, which through neglect may become a chronic suppurating ear. This follows a simple localized inflammation, or, as the laity put it, a "gathering," which the patient and family, too often the family physician as well, neglect at a time when cure might be easily accomplished.

This neglect may possibly be attributed to two reasons:—

1. Carelessness on part of the family, owing to the cessation of the pain with the appearance of the discharge, they taking the relief of pain as an indication that the case is "doing well."

And, secondly, the popular idea that a discharge from an ear should not be checked.

A common, though mistaken, idea that a child will outgrow a diseased condition is responsible for many a defect which eventually becomes permanent.

The erroneous impression exists among the laity, and to some extent among the profession, that a child with a running ear is not in danger if discharge is free.

A chronic suppurative ear is a constant menace to life. The case may extend over a long period of time and serious complications may arise. Meningitis, Pyæmia, Cerebral Abscess, Emboli are some of the sequelæ of a suppurative otitis media. Hence it is of the utmost importance to check a discharge from an ear.

These purulent discharges from the ear are more common in children, and follow as an extension of a pre-existing catarrhal condition of the nose, or from the irritation of adenoids in the naso-pharynx, or even enlarged tonsils, which press on the Eustachian tube, interfering with its function, or again as the sequelæ of the acute infectious diseases, Scarlet Fever, Measles, etc.

Repeated and uncared-for colds furnish another class of cases.

Then in the so-called scrofulous and tubercular diseases we find a tendency to the condition.

Extensive and expensive outfits of surgical appliances are not required to treat suppurative ear cases. A head mirror, a source of light giving good illumination, an otoscope, cotton applicator, an ear syringe and a Politzer bag, or a globe nebulizer, should be on hand.

The careful treatment of the acute stage of an otitis media will often prevent a perforation of the membrana tympani. Absolute rest, light diet, hot fomentations to ear, hot water irrigation and the instillation of Plantago, Belladonna, Mullein Oil will often reduce the local irritation. And along with the local treatment the administration of Aconite, Belladonna, Gelsemium, Ferrum Phos., or whatever remedy may be indicated.

The application of Antiphlogistine, or any of the newer antiseptic poultice pastes to the external meatus, greatly aids in reducing the agonizing pain.

If the pain is persistent and there are evidences of pus in the middle ear, which can only be positively determined by an otoscopic examination, mymigotomy is indicated in preference to allowing nature to rupture the membrane.

The canal is anæsthetized with Cocaine, or Eucaine solution, and under good illumination the membrana tympani is incised in the post-inferior segment, avoiding the malleus. A free incision is made to give the pus free exit. After the incision is made the Eustachian tube should be inflated and the pus forced through the incision in the membrane, the external canal cleansed with Peroxide of Hydrogen, and after thoroughly drying the canal is dusted, not filled, with one of the dusting powders, Aristol, Nosophen, Boric Acid or whatever powder may be the operator's preference. Cleanliness and free-drainage are the indications now, and this applies to the nasal space, as well as to the external meatus. Thorough spraying of the nose and throat with a cleansing solution and following with Camphor, Menthol, Albolene spray will aid in reducing the nasal inflammation.

If the membrana tympani is ruptured by nature the indications for the cleansing and drying treatment are the same.

Many cases when they come into the physician's care have advanced to the stage of carious bone. Here the treatment to be instituted must be thorough. For some years Pepsin has been used to remove this carious bony tissue, but the necessity of having a fresh preparation of the pepsin and hydrochloric acid solution for each treatment caused the treatment to be abandoned by many, until recently "*Enzymol*," a preparation of Fairchild Bros. & Foster, was offered to the profession. It is an extraction from the peptic glands of the pig's stomach, slightly acidulated, and by diluting it with an equal quantity of water we have practically an artificial gastric juice.

Gastric juice will break down dead organic matter. This is its function in the stomach, and if the proper conditions of temperature

and acidity be maintained it will act as well on dead tissue out of the stomach as within it, and it does not affect living tissue. *Enzymol* acts well on ulcers, digesting and dissolving the slough, and it renders good service in cleansing carious cases of suppurating ears.

The patient may be given a bottle of Enzymol, properly diluted with an equal quantity of water, and directed to cleanse the canal thoroughly and then instil four or five drops of the solution, or if sufficiently intelligent may be directed to apply the solution on a pledget of cotton, this treatment to be repeated several times a day.

I do not claim that Enzymol will cure the case, for the digestive ferment treatment must be supplemented by internal remedies prescribed according to indications and also the occasional application of the dusting powder to the canal and the thorough cleansing of the nose and pharynx.

By following some of the suggestions in the paper, I believe we will have less trouble in curing our cases of otorrhœa, although the hearing may be defective and it may be necessary to resort to pneumatic and phonetic massage of the ear after the discharge is controlled in order to improve the hearing.

DISCUSSION.

Dr. H. B. Ware: I was much pleased with this paper; I was especially interested in this new remedy, Enzymol. It is something I have just begun to use myself. I have had no result whatsoever with it, as I have not used it long enough. But it is a remedy that promises a good deal in some of our old chronic cases, where it seems as if nothing else will reach. It offers great inducements to its use in the treatment of middle ear abscess. Last winter I had rather an interesting case in which the mastoid was involved and the irritation began to improve from the time of the treatment. We tried Peroxide of Hydrogen treatment; copious irrigation; also heat. The mastoid was markedly involved; the swelling was considerable and the discharge was so profuse that by pressure upon the mastoid process you could force it out of the ear. This finally healed up; the perforated drum healed up. I had to open it and during this time I was ready to do a mastoid operation, but the hot application did more than the other local remedies, although the treatment was intended to keep up drainage and favor the opening of the drum. I did not make a poultice as it usually is made. A poultice to the ear should not be in a bag put over the ear. There should be a perforation, so

that the lobe of the ear can come through and thus apply the heat directly to the mastoid and also in front of the ear, and cover a piece of flannel or something over it. You then get heat directly to the parts. If you make a bag poultice, or make a hot-water bag, you will cover up the principal part where the heat should be supplied. This is one of the specially interesting points in applying the heat. This case got well and healed up without any mastoid operation at all. If we had followed the ordinary treatment and not used the hot appliances I believe we would have had to go into the mastoid.

Dr. T. S. Dunning: I would like to ask Dr. Schantz how he applied the antiphlogistine. Did he apply it directly within the ear?

Dr. H. F. Schantz: By taking a bit of cotton and applying the antiphlogistine on the cotton and passing that pledget in.

After applying antiphlogistine in twenty-four hours it dries, like a dried cake mass, which washes off; washes right off. I do not know whether it dissolves. The water becomes perfectly cloudy. I do not know whether it dissolves, but it mixes; I know you get rid of it.

Dr. J. W. Coolidge: The important point is to recognize these cases immediately. The general practitioner gets them before the specialist receives them. You find them among the children. I think it is of the greatest importance that the general practitioner should make this his one specialty, the early recognition of these cases of middle ear trouble in children, not to pass them by unnoticed. I know in my daily rounds the mother will tell me the baby kept her awake all night with the ear-ache. The pharyngeal opening, the Eustachian tube, is closed, and there is the atmospheric pressure which drives the drum membrane back, and you get suction and inflammation right away. I think these cases could be relieved by the general practitioner if he understood the rationale of the condition. I think the point in all this discussion is to impress on the general practitioner the importance of the early recognition of these cases.

Dr. E. W. Brickley: In reference to that new remedy known as Enzymol, I selected it as a weapon of defense against these old-standing, foul cases of otorrhœa, and for a time abandoned my regular routine practice in these cases. I gave it a thorough, conscientious trial, and it has been weighed and found wanting. To simply syringe an ear out with that preparation, and, as they say, not thoroughly dry it, leaves the ear in the condition you want to avoid—wet. I think that has as much to do with my want of success as anything

else. I followed the directions for its use and thought they knew how it would act. I have discarded it.

Dr. H. F. Schantz: Did you try drying the ear and washing it out afterwards?

Dr. E. W. Brickley: Yes; I had no result with it at all.

PILOCARPINE IN OPTIC ATROPHY—TWO CASES.

E. W. BRICKLEY, M. D., YORK.

The presentation of this article is prompted, not by a desire to present anything new in the way of therapy in the treatment of optic atrophy, for the field seems well-covered at this time; but rather to encourage persistent effort in the endeavor to cure that class of ocular trouble which the pathologist so beautifully describes, but for which a complete cure, or even a partial restoration, seems yet to be in the realm of the possibilities rather than the probabilities.

We are all familiar with the objective signs of a case of atrophy, either partial or pronounced, from the time when the veil of smokiness begins to alarm the patient to that period in its progress when the increasing pallor of the disc, of various shades, only too plainly portends the final dropping of the curtain of eternal darkness. We have felt most painfully our impotence to aid, and have bidden the stricken one hope for the best, only to see him in the end awake to the full realization of the hopelessness of the effort.

The routine course of treatment noted in most text-books would seem to be Strychnia, either alone (by stomach or subcutaneously), or in combination with Phosphorus in some of its forms—the Mercurials or Potass. jod. in various degrees of dosage.

Pilocarpine, once extolled, seems to have fallen into the common therapeutic rubbish-heap, and in a number of authorities consulted it was found mentioned in but one—De Schweinitz.

Why it has been discarded is not quite apparent, unless it was thought to be as slow and uncertain in its action and results as were other agents, but in my hands at least two cases treated with it exclusively and persistently, when vision in one of them diminished to fingers at a few inches, have to thank this agent for the practically perfect sight which they enjoy today. It is my purpose therefore to briefly as possible present these cases at this meeting, leaving the dis-

cussion as to the "rationale" of the treatment to those it may interest sufficiently to discuss it.

Case I. Geo. A. H., age fifty years, was brought to my office by an interested friend in great mental distress, giving me the following history:

Five or six weeks previously, while in our city on a business trip, he had been seized with what he termed a terrible neuralgia in the frontal region, which caused him to seek a general practitioner for relief.

Two doses of a drug, the name of which he did not know, were administered before he experienced cessation of pain, and almost simultaneously vision began to become smoky.

This persisting for several days, he became alarmed and consulted an oculist; had treated him by internal medication during the entire time previous to his visit with no benefit; in fact, he was getting steadily worse.

The eyes presented the characteristic stare and fixed objects with difficulty; pupils dilated and responding but feebly to light stimulus; the papillæ were of pale, bluish white color; edges sharply outlined; vessels thinned and lamina cribrosa slightly glistening—

V. O. D. $= {}^{6}/_{60}$ — V. O. S. = fingers (only) at 10 inches; lenses tried; did not improve.

Taking it for granted from his story that he had already been put through the usual Strychnine course, it was determined to give the Pilocarpine treatment a trial, this having been used successfully in several similar cases during the course of study in the clinic of Fuchs at Vienna in 1890.

An eighth-grain of the hydrochlorate was administered hypodermically in the right temporal region, and after the usual diaphoretic action had subsided he was told to report daily for the injection, which he did faithfully until ordered otherwise.

A record made March 16th, 1895, shows a marked improvement—V. O. D. $= {}^{6}/_{18}$ = V. O. S. fingers at 3 feet.

Some slight conjunctival disturbance at this time required the use of Collyr. Ac. Boric (saturated).

The improvement thus begun continued under this form of treatment (the intervals between the injections being lengthened according to the progress of the case), until the date of his discharge, December 4th, 1896, when vision for both eyes was normal and he was given + 2.50 D. V. e for a reading correction.

As his recovery progressed the drug was given "per orem" entirely, the hypodermics being abandoned after the sixth week. It should be mentioned that the color sense was much impaired, green being invariably mistaken for brown, while red was faded and uncertain.

Since his discharge, four years ago, he has had one relapse, which Pilocarpine again administered promptly controlled in two months' time.

The discs still present some pallor, but vision at this time is all that could be desired.

Case No. 2 was that of a shoemaker, H. A. S., sixty-eight years of age, who consulted me on January 5th, 1898, giving a history of failing sight during the previous five months.

Was always obliged to use his eyes very hard working at his trade and thought they were "overstrained."

The left vitreous was full of opacities; both discs seemed paler than normal and of bluish cast, while the vessels were more or less shrunken; some conjunctivitis due to slight entropion was also present. Reflexes fair—

V. O. D. $= {}^{65}/_{24} + 1.50$ D. $= {}^{6}/_{9} =$ V. O. S. $= {}^{6}/_{60} + 2.00$ D. $= {}^{6}/_{24}$.

A rather shady history of habits in early life led me to prescribe during the first three weeks a Sol. of Potass. jod. ℥j to fl. ℥j water. Dose, gtts. v 3 t. d. after meals; but as it seemed to have no beneficial effect, and caused pronounced digestive disturbance, it was abandoned, and Pilocarpine bichlor. gr. $^{1}/_{8}$ given hypodermically in the arm.

These injections were made weekly, the patient being from a distance and unable to make daily visits, and in the interval he was ordered to take a quarter-grain tablet once daily at his home.

The drug effect from this dosage proving too exhausting, it was afterward reduced to gr. $^{1}/_{8}$.

From this time his improvement began, and a record made March 23d, 1899, shows—

V. O. D. ${}^{6}/_{36} + 2.00$ D. $= {}^{6}/_{6}$.
V. O. S. ${}^{6}/_{60} + 1.50$ D. $= {}^{6}/_{12}$.

On January 1st, 1900, V. O. D. + D. $= {}^{6}/_{6}$
V. O. S. + 2.00 D. $= {}^{6}/_{6}$ } Distance.

And he is given + 5.50 D. V. e for close work.

In June of this year he returned, saying that one week before he noticed objects appeared covered with a white powder and more hazy.

He was at once given Pilocarpine, as before, and on August 21st, 1900, reported all trouble to have disappeared, although the papillæ still retain in some degree their pallor.

Both of these cases are being kept under observation for fear of a relapse, but if we have succeeded in postponing, for a time at least, the loss of vision usually so certain to occur, we have made a stride forward in the handling of a class of cases most pitiable and undesirable.

DISCUSSION.

Dr. H. B. Ware: I have not had any experience in these cases with Pilocarpine. I have had some success in chronic cases, where I have been able to stimulate the optic disc and where there seemed as if there was almost no vision. I remember a case a long time ago that came to me—a young woman; she could see, I think, it was three-fifteenths, and that very dimly. There was a great haze in front of her eyes. I treated her a long time with all remedies, but nothing seemed to stop the progress of the trouble at all. I investigated, and after treating her for some time I used the Iodide of potash, put her on treatment for whatever absorptive action the remedy might have, and it seemed as though I got a result; afterwards I found she had a nasal trouble. Whether this is what aided or whether it was the Iodide of potash I do not know. I do know that with the two she gained a great deal, so that she could get around. I do not recall the exact vision, but the last report I had of her was that she went from the Forty-second Street Station to the D., L. and W. Station, in New York City, which is across town, and she was able to get around all by herself. I think this would explain better how much vision she had rather than giving the exact figure. She did this herself, got on the right cars without asking, and safely reached her destination. I believe in a great many cases of optic atrophy nasal irritations have a great deal to do with the eye defect, and if these can be removed there may be obtained a certain amount of vision. But in other cases—acute cases—I have never had any in my experience. My cases were of chronic character, of some years' duration. I cannot state that I have made any cures like those of Dr. Brickley, which, however, I do not question. However, I question whether any chronic cases could be relieved by Pilocarpine alone. You would require other remedies and remove

other causes of the disease which act reflexly. I should like to know whether Dr. Brickley has used Pilocarpine for chronic cases of some years' standing.

Dr. E. W. Brickley: No.

ECZEMA OF THE EXTERNAL AUDITORY CANAL.

BY H. K. HOY, M. D., ALTOONA.

This affection is not different from eczema located elsewhere upon the body, except in so far as the nature of the parts involved is concerned. My experience has been that in this location the disease has been very intractable and results are unsatisfactory.

I think I can supplement the homœopathic treatment in these cases by a local application that is quite effective. The subjective symptoms are itchings and sometimes impaired hearing, while the objective symptoms are crusts or scales, either dry or with an admixture of cerumen. The plan of local treatment that I have adopted for some time, and which has given the best satisfaction in these cases, is to thoroughly cleanse the canal with Peroxide of hydrogen, giving it plenty of time to macerate foreign matter, and then to remove with a dry, cotton probe everything unnatural and apply a solution of Pix creosol, six grains to the drachm, or stronger, if this does not seem sufficient. In applying it I use a cotton probe, steeped in the solution, and rub thoroughly every possible part affected. This invariably stops the itching for a time, and should be done every second or third day for several weeks, and again resorted to if the symptoms appear after there seems to be a cure.

Just how much this treatment has to do with a cure I do not pretend to state; but this I know, that since I have been treating patients thus quite a number have apparently been cured. I give internal remedies at the same time, and where I find deafness I treat it the same as in other cases of that trouble. If due to internal ear disease I rely wholly upon medicines, but with no great hope of restoring the hearing and often get no result. If due to middle ear disease I resort to massage, which may or may not do good (this procedure has been introduced too recently to estimate its value) and inflation, which in many case does the work.

There is one class of people, however, in which good results as a

rule cannot be counted on to restore hearing, and that is the boiler-makers, unless they change their occupation.

DISCUSSION.

Dr. E. M. Gramm: Mr. Chairman—I would like to say a few words in regard to eczema of the external auditory meatus. It seems to me that, while Dr. Hoy has picked out one remedy, which is Creosol, as a local application, it is, however, exceedingly important to individualize your cases of eczema of the external auditory meatus just as you would individualize them anywhere else. Of course, in the external auditory meatus you have what are analagous to sebaceous glands. The glands which produce the cerumen are, of course, differently constituted, as their secretion has a different function from that of sebum. It is the involvement of these glands which many times keep up the inflamed condition within the ear, and on that account it is necessary to treat the case from the standpoint of a deeper inflammation than the inflammation of the rete mucosum, which constitutes eczema. Personally, with eczema of the ear, I have no trouble whatever; I mean of the external ear. I am confining my remarks to the external auditory meatus, not to the skin of the outer ear. You have, of course, the cerumen, as I remarked before, to deal with. You have there an increased quantity to deal with; you have an altered quality of material to deal with and a more liquid condition of this cerumen. You have at times inflammation of the glands that goes on to pus formation, being similar to the inflammation of the sebaceous glands of the hairy portion of the face—sycosis—and on that account you need antiseptic measures in such an event.

Ordinary eczema of the external auditory meatus is very rapidly cured by swabbing the ear with a solution of five grains of Salicyclic acid to an ounce of olive oil. This oil cleanses the canal; as is necessary to be sure nothing is left there. This is no different from the same disease in any other location. You need to remove the products of the disease before your remedies can reach the site of the disease; you need to keep it clean and then apply your Saliccyclic acid in olive oil. If the case is of a more aggravated type, a very thin ointment base, such as vaseline or cosmoline, with a little ammoniated mercury, five grains to the ounce, or ten grains to the ounce, can be used, and the ear swabbed out with that. Then, we have the ichthyol for still more intractable cases, and where the cases are still more intractable we use a mixture of ichthyol, five or ten per cent.; two

drachms of Zinc oxide, two drachms of starch and four drachms of vaseline. I think you have an ideal treatment for each variety of external auditory canal eczema, but the fact that the doctor has relieved these cases rapidly with Creosol is, of course, to be borne in mind. He gave us another remedy, and he claims that almost every case he has treated has had the itching relieved by it right away. Salicyclic acid will do the same. Cleanliness, above all else, is a necessary thing in eczema.

I would like to call attention to the fact that many times eczema of the external ear has its beginning in the canal, so that merely prescribing your graphites, because of the sticky discharge of the external ear, cracks back of the ear with sticky discharge or petroleum, because the condition is in front of the ear, will not help you. You are not reaching the seat of the trouble; you need in addition to clean out the canal. It must be borne in mind, too, that many cases of eczema of the external auditory canal are produced by carelessness on the part of the patients. Patients will take hair-pins and tooth-picks and even pen-knives to clean the ear, because they cannot hear well, when the difficulty is in the Eustachian tube; or, perhaps, they have been to the seashore and the cerumen has become impacted and they attempt to dig it away. Remember, the cleansing, and the fact that you have a deeper involvement than a rete mucosum involvement in a great many cases.

Dr. E. W. Brickley: In my experience as a specialist of ten years' standing it has been almost invariably the case for me to find that eczema of the auricle, or of the canal, is due to a perforation of the membrana tympani. I admit that there are constitutional cases in which there seems to be no assignable trouble in the middle ear, and I have struck those cases, but they are comparatively rare. In the majority that I have had to deal with there was nearly always present an otorrhœa, due to a middle ear suppurative process, which was primarily the cause of the trouble. Therefore, the first thing to do is to cure the middle ear trouble, and I cannot too highly extol the use of first thoroughly cleansing; it is paramount to everything else. Next to that the use of the Peroxide of hydrogen, and I prefer the Oakland Chemical Co.'s. The Oakland Chemical Co.'s product seems to give me the best satisfaction. Then, after allowing it to "boil," so to speak, thoroughly syringe it with a carbolized solution of tepid water and dry the cavity thoroughly before applying any other ointment. I lay special stress on the drying, because in all cavities of the body you have the one prime element of decom-

position present—heat and moisture. Dry thoroughly. And I have used with a great deal of success a preparation of boric acid in combination with calendula. I did at one time use the pure Boric acid, and found that was not so satisfactory. Calendulated Boracic acid has no tendency to cake. Placed well up into the attic it seems to do the work very well. My guiding symptom as regards renewing the treatment is never to disturb that ear as long as the cotton plug shows no evidence of discharge. I think there is more harm done in these middle ear cases by continuing the use of a stream of water, forcibly directed against the opening which nature has tried to heal, and which the syringe will invariably tear further open. There is more harm done in that way than if you allow nature to have a fair chance. If the cotton wad is not discolored, let it severely alone. When you find the powder is more or less under the influence of the discharge, and the cotton shows some discoloration, then is the time to clean. If that cotton is discolored several times a day clean your ear that many times, and I have been able to cure cases of eczema of over eight years' standing with almost total destruction of the drumhead. One man whom I cured is filling the office of associate judge in one of the courts of Pennsylvania and is very grateful for the results obtained.

As regards eczema, I have found the yellow Oxide of mercury ointment well-applied after thoroughly cleansing and drying very useful. I have that spread on cotton at night time; the cotton well-depressed into the furrows of the canal and kept in place until the next morning;; then wash off with castile soap and powder with Zinc oxide. It is rare to have eczema last over two or three weeks at most. Of course, everyone will strike intractable cases. I have found an ointment, known as Unguentum betula comp., which has been acting very favorably. I confess I am not perfectly cognizant what enters into that ointment, but I am sure there is a great deal of oil of tar. Possibly that is put in to disguise the true nature of it more than anything else, and I know it has a beneficial effect.

My mainstay has been to correct any discharge,—in most cases I have found that the eczema present then will take care of itself.

Dr. H. B. Ware: I would like to ask Dr. Gramm whether or not the coal-oil preparations, albolene or vaseline, are not detrimental. I have used them and I have used petroleum in various forms as an agent for applying other remedies, and I have found every time that I have used them as a body my case would not improve. Where

I have used it with other remedies I would get a result. I would like to know whether that is his experience.

Dr. E. M. Gramm: I do not think I can say that I have ever had irritating results, except when I used the wrong ointment; that is, the wrong remedy. I have used different bases, but I prefer the petroleum jellies. I have never used albolene, or liquid vaseline, but incorporate the various medicaments with the solid ones. I have used vaseline, cosmoline, lucilline and petroleum, and none of them produce any irritation. Of course, when I spoke of petroleum, I meant the potentized remedy given internally; I would not use petroleum as a local remedy.

REPORT OF THE

SECTION OF OBSTETRICS.

Ectopic Gestation; a Report of Three Cases, by Edward W. Mercer, M. D.
Nausea and Vomiting of Pregnancy, by Ella D. Goff, A. M., M. D.
Post-Partum Hæmorrhage, by D. C. Kline, M. D.
Influence of Neurasthenia on Pregnancy and Parturition, by E. T. Schreiner, M. D.
Diseases That Are Benefitted or Aggravated By Pregnancy, by Anna Johnston, M. D.

ECTOPIC GESTATION; A REPORT OF THREE CASES.

EDWARD W. MERCER, M. D., PHILADELPHIA.

My reason for selecting this somewhat hackneyed subject for my paper is that just about the time when a choice could be postponed no longer there came under my care within a few weeks three cases of extra-uterine pregnancy, which again directed my attention to the fact that this is not an infrequent obstetrical complication, and one of these cases particularly illustrates the importance of their early recognition and prompt treatment.

In the recent text-books on obstetrics considerable space is very properly devoted to a methodical consideration of this important subject, its etiology, pathology, diagnosis and treatment. These are accessible to us all and an occasional perusal will be of immense advantage to us in serving to keep constantly before us the clinical picture of these most important and alarming cases. It is not my purpose to give a resume of what has been written on this topic, nor to make any lengthy report of ectopic cases, but briefly to relate the clinical courses of these three cases, which have so recently come under my observation, and perhaps draw attention to a few features in which there was a deviation from the usual symptoms of such cases.

The first of these is not the kind we are particularly fond of relating on account of the unsatisfactory result, but these, however, are often as instructive as those which have terminated more happily, and at times even more so.

Case 1. Mrs. B., aged thirty-five; seen with a colleague on July 3d; gave the following history: Had borne six children; no miscarriages;

last pregnancy terminated normally eighteen months ago. After the usual period of lactation had menstruated regularly until March and April, when the flow was absent. About this time she developed symptoms of pregnancy. In May when washing there occurred a gush of blood; this was so profuse that she supposed she had aborted, and from this time on she continued to have more or less bloody vaginal discharge. Following this sudden flow she experienced a sensation of relief, but a short time afterward she began to have severe abdominal or pelvic pains. Prior to this time she had had no medical attendance, but her pain now became so severe that a physician was called in, and during the succeeding three weeks she had two or three, until June 25th, when my friend saw her. At this time she was suffering with excruciating pain, worse in the right side of the pelvis, for the relief of which it was necessary to administer an opiate. She was having a constant bloody offensive vaginal discharge, containing apparently shreds of decidual tissue. She had a slight elevation of temperature, reaching at mid-day between 100 and 101. The patient was quite inclined to obesity, and the abdominal walls were so thick as to considerably interfere with an exploration through them; but a vaginal examination showed almost the entire pelvis to be filled with a hard sensitive mass, which rendered the outlining of the pelvic organs impossible, but apparently the uterus was displaced forward. An absolute diagnosis was not made in this case. There was a strong suspicion of ectopic gestation, with a possibility of its being a septic pelvic inflammation resulting from infection from the uterus. It was certain she had a putrid endometritis. Accordingly I advised that the patient go to the hospital, where under an anæsthetic the uterus could be cleaned out and a more careful pelvic exploration made preparatory to an abdominal operation. She was admitted to St. Luke's Hospital July 4th in fairly good condition, with a moderate amount of anæmia, with a temperature of 100.4, pulse 80.

On the following day under ether the uterus was carefully curetted, a small amount of shred-like tissue being removed, but an examination being made at this time did not reveal anything more definite than the previous one. During the operation the patient was somewhat shocked, more so than is usual from such comparatively trivial operations. However, she afterward reacted and her condition during the following night was fair. Early next morning I was notified by 'phone that after a severe attack of abdominal pains the patient suddenly developed symptoms of collapse, rapid pulse, becoming almost imperceptible; pale face, etc., etc. I instructed the residents

to infuse with normal salt solution and started for the hospital prepared to open the abdomen, but upon my arrival I found her moribund, not having reacted after the infusion, and in a few minutes after my reaching the hospital the patient died. An autopsy made in this case revealed a rupture of the right tube, from which there had escaped an ovum containing a fœtus in the third month of development; a large pelvic hæmatocele, and free blood in the abdominal cavity, evidently from a secondary hæmorrhage, resulting in her death.

A misleading feature of this case was the history of an abortion several weeks previously, and to corroborate this a vaginal discharge indicative of some retention of the products of conception. This latter may be explained now probably by infection occurring from the examination and manipulation during the weeks of her treatment of the decidual tissue contained within the uterine cavity. The condition of the patient did not seem to demand the opening of the abdomen; at the same time the uterus was curetted, thereby increasing the chances of infection from its putrid discharges, but whatever the ultimate result might have been our conservatism on this occasion was not very satisfactorily rewarded.

Case 2. Mrs. M., aged thirty; came to my office July 17th; her history is as follows: Has borne three children, the first in 1888, the second in 1890 and the third in 1894. About one year later she had what may possibly have been an abortion in the early weeks of gestation. Since that time until June 10th of this year has been well, menstruating regularly with but slight pain, the flow being rather scanty, lasting two or three days. I might say that three months after the first child was born, in 1888, I treated this patient, the record showing her to be suffering from sub-involution, endometritis, with a prolapsed ovary, the side not noted. At this time she was curetted.

On June 10th, when the menstrual flow should have occurred, there was but a slight show and since then there has been an irregular scanty intermittent flow. At the same time, June 10th, she was taken with severe pains and cramps in the right side of the abdomen or pelvis, lasting five or ten minutes. In about one week she had a second attack, the pain during this one being even more acute and intense than the first time, and following there was a period of ten days or two weeks, when the attacks were daily, but less intense, these finally subsiding into a steady or continuous pain. The

modification of her suffering may have been due to treatment received at this time, the character of which I do not know.

On July 17th, when I first saw her, an examination showed the abdomen distended and sensitive, the cervix somewhat forward, the body of the uterus slightly enlarged and displaced to the left side. In the right lateral region there was a sensitive mass about as large as a small orange. The diagnosis of ectopic gestation was made and the patient advised to go to the hospital for immediate operation. She was admitted to St. Luke's Hospital July 19th, having on admission a temperature of 99.2, pulse 86, and on the following day I opened the abdomen and found no free blood in the cavity, but the right tube distended, the walls partially ruptured, the Ostium Abdominale dilated and a good-sized hæmatoma circumscribed by the folds of the broad ligament, and bands of adhesion about the fimbriated extremity, the ovum remaining in the dilated tube. The mass was removed and the patient promptly recovered from the operation, being discharged from the hospital on August 11th, her twenty-first day.

Case 3. Miss R., aged twenty-eight; occurred in the practice of the physician with whom I had seen the first case. I saw her with him July 26th. The previous history of this patient I deem a little unreliable, as she was unmarried, but had borne one child; just when I do not know. However, she claimed to have menstruated regularly until six weeks before, since which time she had had a continuous scanty flow, in which there was noticed no shreds of membranes or clots. Four weeks before she began to have sharp cramp-like pains in the left side of pelvis. At first these pains were intermittent in character, but for the last two weeks had been almost constant, with exacerbations at times, when they were so intense as to be unbearable, the use of an anodyne being necessary to relieve her agony.

On examination the uterus was found to be enlarged and displaced toward the right side of the pelvis by a large mass involving the left lateral region and extending into the cul-de-sac. A diagnosis of ectopic gestation was made and operation advised. Accordingly she was sent to St. Luke's Hospital on August 1st, on the afternoon of admission having a temperature of 99 and pulse 80. The next day I opened the abdomen and found a rupture of the left tube, the ovum remaining attached to the tube wall, and a large hæmatoma of the broad ligament, which with the tube and ovary were removed. The subsequent course of the case was uneventful, she being discharged from the hospital on August 22d.

In this class of cases there are not I believe very many symptoms which are constantly present upon which a diagnosis may be based, especially early in their course. In these which I have mentioned sterility was not a feature, the first case having an infant eighteen months old, and in the others this was so uncertain as to be of no diagnostic value. In only one of the three was there a cessation of the menstrual flow, but in all was this function disturbed. In but one of them were there any symptoms of pregnancy obtainable.

One of the most reliable subjective symptoms, and at the same time one most constantly present which will lead us to suspect this condition, is I believe the terrific pain that these patients complain of. In all these cases, for instance, they described them as simply maddening, it being necessary to restrain them in bed when the paroxysms came on, and that very generally is the character of these pains. If we have accompanying this pain a mass to the side of the uterus in the region of the tube, and perhaps involving even more of the pelvis, extending toward the cul-de-sac, with menstrual disturbance, and this may be either cessation of the flow, irregularity or a constant discharge, we have a picture which will usually justify us in diagnosing ectopic gestation, and promptly instituting treatment.

Since writing the above a case of interest in this connection claimed my attention:

Mrs. W., aged fifty-four, I saw on September 13th; she gave a history of having had three children, menses irregular, lasting two days, accompanied by severe pain. Several weeks ago, some time in July, she began to complain. There was some swelling of the abdomen, a continuous bloody discharge from the vagina, containing shreds of tissue, which has continued to the present time. There have been at intervals during this period attacks of nausea and vomiting; there has been also more or less abdominal pain, particularly in the left side. Some time in August she was taken with very severe pain in the side, which, however, gradually subsided, and she was able to be about following her usual occupation. Thirty-six or forty-eight hours before I saw her the physician was summoned during the night. He found her suffering with agonizing pain in the left side of abdomen and in a condition of collapse. When I visited her she was, according to his statement, somewhat improved, but I found her with symptoms of beginning peritonitis, temperature 102, pulse 120; the abdomen was so distended that nothing could be felt by palpating; a vaginal examination revealed nothing. Here was a pa-

tient who presented many of the symptoms of an ectopic gestation, but there was lacking the tumor in the region of the tube. The patient was immediately sent into the Hahnemann Hospital for operation.

On opening the abdomen I found a fair-sized multilocular cyst of the left ovary, with a long pedicle, which had become twisted and causing necrosis of the tumor.

DISCUSSION.

Dr. W. G. Dietz: I think perhaps some of the older members will remember that many years ago Dr. Bullard, of this city, reported a case of ectopic pregnancy in a colored woman. As I recall the facts the symptoms persisted for a period of time which I do not now remember. Finally the bones of the fœtus were discharged per rectum, with some mechanical assistance. The patient was probably not recognized as being pregnant, but the case was finally cured by nature. Perforation and ulceration of the contents of the sac had taken place, with discharge into the rectum and cure of the patient. I think that Dr. Bullard if he was here would relate that case. It was many years ago when it happened.

Dr. John E. James: You will find in the literature a good many such cases where it was not recognized what was the trouble, and nature often brought about a cure. It assisted it to remove the blood, leaving the bones to work out here and there, fortunately a good many of them in the rectum, thighs, loins, some one or the other way.

Dr. E. W. Mercer: In reference to the case of which Dr. Dietz speaks that is one of the methods of termination, it is a very fortunate method of termination when they are allowed to the efforts of nature. The percentage of mortality in those cases is high; I think 60 or 70 per cent. By prompt treatment we only have a mortality of six or seven per cent.

NAUSEA AND VOMITING OF PREGNANCY.

ELLA D. GOFF, A. M., M. D., ALLEGHENY.

Among the complicating symptoms of pregnancy none are more annoying and distressing than the nausea and vomiting affecting the majority of cases, few escaping, which occur in all the various forms, from the slight nausea present on opening the eyes to the pernicious vomiting, causing anæmia, emaciation and frequently demanding the induction of premature labor in order to save the life of the mother.

The lighter forms of this malady seldom come to the notice of the physician, as they frequently disappear during the first weeks of pregnancy, while the continued and more severe symptoms demand constant attention and thoughtful care.

Many theories have been advanced as to the cause of these conditions, the most prominent of which are congenital irritation of the nervous system, producing exaggerated response to the normal reflex stimuli; anatomical lesions of the genital tract, malformations, dislocations, mechanical injury, or violence to the pregnant uterus; distention of bladder and rectum, movements of fœtus in utero.

Whether the causes be physiological or pathological, and the question I believe is still one for debate among scientists, it is the duty of the physician to relieve the conditions as best he may.

Frequently the indicated remedy is all that is required to alleviate the distress, especially when it is not caused by irritation in the genital tract or displacements. Should this occur the suffering can often be reduced to a minimum by the use of a medicated tampon, which not only gives support to the parts, but also stimulates and relieves the congested condition.

With the greater number of these patients it is my custom to use a glycerole with hydrastis, together with the indicated remedy. The results are as a rule successful, and after several applications relief is obtained.

Where a neurotic condition prevails and a careful examination convinces that no lesions or irritation exists the following remedies have been used with good results:

Cocculus.—When the head feels dull, dizziness and numbness, every sound startles, trembling over the body, foul taste, acidity of

the stomach, nausea on waking, which is exaggerated by eating, talking, or drinking.

Pulsatilla.—Eructations after eating, nausea, water brash, even the smell of food causing gagging.

Nux Vomica.—Fullness in the epigastrium, vomiting of sour food and drinks, most foods causing nausea, patient weak and somewhat constipated.

Arsenicum.—Patient cannot retain any food, even a drink of water causing distress.

Bryonia.—Every time the patient moves, goes up or down stairs, is retching and vomiting, especially when rising from a recumbent to a sitting posture.

Phosphorus has been found successful after Arsenicum and Pulsatilla have failed.

Petroleum.—When vomiting is caused by seeing moving objects, as some one rocking.

Sulphur relieves many severe cases.

Psorinum also relieves in extremely severe cases, when all other remedies have failed to produce the desired results.

Palliatives.—Compresses of ice water or ice bags placed over the stomach, hot compresses, poultices of hot corn meal, compresses wet with brandy, fomentations. Slight dilatations will frequently afford relief and not produce abortion; champagne given in sips is effective in severe cases.

DISCUSSION.

Dr. W. G. Dietz: Of remedies for this disorder there are many—one, Antimonium crudum, where the tongue is coated white; when all other remedies apparently fail Antimonium crudum gives relief. Where the nausea is the sole symptom present Ipecac. should not be lost sight of, and Sepia has relieved where it has seemed necessary to induce abortion to save the life of a mother.

Dr. Sarah J. Coe: I have found it very helpful in the nausea of pregnancy to dilate the cervix and returning to its normal position a retroverted or anteverted uterus. It has helped every time.

Dr. Frank Harpel: There is one other remedy, and that is Tabacum. I have used that in a great many cases and found it very useful where nausea has persisted and where even the smell of food would nauseate.

Dr. Goff: What potency of Tabacum did you use?

Dr. Harpel: From the third to the sixth.

POST-PARTUM HÆMORRHAGE.

D. C. KLINE, M. D., READING.

During my first years in the practice of medicine there was no complication or condition so thoroughly feared, or that caused such a needless expenditure of nerve force, as the possibility of a post-partum hæmorrhage. I had heard the question propounded by our good old friend, Prof Gause: What to do in the event of post-partum hæmorrhage? and had heard the student reply—*ligate the post-partum artery;* but this did not enlighten me in the least.

I say *needless* expenditure of nerve force, because the good Lord protected me from any such severe cases for some time, and thereby kept me in the medical ranks; for had it been my fortune to have encountered a serious after-flooding during the first dozen obstetrical cases attended (such as has since been my lot) me fears it would have swept me out of the profession, if not out of existence. Fortunately post-partum hæmorrhage does not occur as frequently as the novice in the profession might anticipate; but when it does come we should be ready to meet it.

There is no more trying ordeal for the obstetrician than a severe hæmorrhage. He must by no manner of means appear surprised or frightened, but must be calm and collected; have his wits at his command; know just what to do, and how to do it; he must act quickly and promptly, but without apparent haste; if patient and assistants see his alarm or fright they lose confidence, and the safety and life of the patient will be jeopardized.

In fact, no one should attempt to serve as an obstetrician unless confident of his ability to cope with post-partum hæmorrhage (here is one serious objection to the midwife).

While the accident usually occurs within a few hours after labor it may appear several days later.

Causes.—Post-partum hæmorrhage may be occasioned or induced by various causes,—as Atony of Uterus, deficient uterine contractions, degeneration, retained placenta-coagula or clots, polypi, lacerations, inversions, rupture of uterus, hydramnios, excessive quantity of Liquor amnii, twin pregnancy, or where uterus has been excessively dilated from any cause, and especially if not thoroughly

healthy we are more liable to have hæmorrhage, rapid delivery, frequently recurring pregnancies, undue exertion or excitement of the patient, causing a relaxation of the uterine walls and clots forming and hæmorrhage ensue.

A woman who has suffered from post-partum hæmorrhage should always be guarded during subsequent confinements.

Symptoms.—There may be an excessive flow of blood or a concealed hæmorrhage, filling up the cavity of the womb. Uterus will be found soft and flabby, and the usual symptoms of hæmorrhage from any cause, as weak, sickly pallor, feeble, frequent pulse, dyspnœa, desire for air, restlessness, thirst and if hæmorrhage continues syncope and eventually death.

A concealed hæmorrhage is oft-times the more serious form.

Treatment.—The treatment of post-partum hæmorrhage must of course vary somewhat in accordance with the cause or origin of the hæmorrhage; but in the majority of severe cases we have to contend with, the bleeding will be found to come from the placental site after the expulsion of the fœtus.

The blood vessels of the uterus are more or less torn by the separation of the placenta, and we would invariably have excessive bleeding were it not for nature's wise provision in the formation of coagula and the prompt contraction of the uterus.

The longitudinal, oblique and circular fibres of the uterus, jointly contracting and pulling, virtually act as many little ligatures around these bleeding vessels, and they are closed and the hæmorrhage avoided.

Then the site of the placenta attachment is the origin of the serious post-partum hæmorrhage most frequently met with; and the most common cause is frequently avoidable, viz., the retention of portions of placenta and secundines, as they retard the normal uterine contractions, and hence the most important treatment is preventive by positively knowing that we have emptied the uterus.

Inefficient or weak uterine contractions during the first and second stages of labor should cause us to be on the lookout for trouble.

One important means of preventive treatment is uterine compression, viz., the grasping of the uterus through the abdominal walls by the hand of accoucheur or assistant during delivery of fœtus and placenta, and following it down, thus stimulating contractions.

The patient should be kept perfectly quiet in the recumbent position, lowering head and shoulders and elevating the hips. If the hæmorrhage occurs soon after delivery, and the uterus is still suffi-

ciently open, grasp the fundus with one hand and make compression and quickly introduce the other into the uterus and empty it of placenta or clots, but keep the hand there in order that its presence as a foreign body may evoke uterine contractions.

The moderate pressure upon the uterus with gentle kneading should be continued, but it should be done with care, as rough squeezing or pressure might do serious damage to womb or ovaries.

If the uterus is emptied of placenta and clots and the hæmorrhage continues we may use the Anteflexion method—introduce two fingers posterior to the cervix within the vagina and press forward, and with the other hand upon the abdomen press the fundus well forward, thus producing a complete and exaggerated anteflexion of the uterus, bending the cervix well up to the fundus, as though endeavoring to double the uterus upon itself.

Another method is to elevate the patient's hips and limbs six or eight inches and lower the head and shoulders, then pressing back the intestines depress the abdominal walls just above the uterus and to left of median line until the pulsations of the aorta is felt, when by gentle pressure one can largely control the supply of blood to the womb.

These methods will afford at least temporary relief and give time sufficient to do something more definite.

Medicines should be wisely considered as soon as possible; and a proper selection made and administered by mouth or subcutaneously, China, Ipecac., Bellad., Sabina, Millefolium, or what seems to be the proper one. As an expedient a tablespoonful of vinegar will many times serve well.

Ergot, the great standby of many physicians, will aid you many times, but I am thoroughly convinced that the mistake is too often made of prescribing it in too large doses; from 5 to 20 drops will serve you much better than one or two drachms, and the effect will be more permanent. Usually it should be given subcutaneously about the abdomen or thighs, as it acts too slowly when given by mouth in a severe hæmorrhage.

A towel wet with cold water and flapped over the uterine region, water splashed or poured from a height upon the bared abdomen, will many times excite uterine contractions; ice may be applied to the abdomen, or pieces passed into the vagina or even into the uterus. Injections of hot water, temperature from 110 to 120 degrees, thrown into the uterus, several quarts being used continuously, or alternately very hot and very cold water.

Remember, however, that water of a moderate temperature will tend to relax the uterus and increase the hæmorrhage.

Vinegar, preferably hot, injected into the uterus, is in my judgment one of our best helps, or the vinegar can be used by saturating a piece of gauze or clean linen and carry it well up into the uterus and swabbing it out or allow it to remain there for a time.

I have usually used the hot water injection first and in the meantime had the vinegar heated, diluted with an equal amount of hot water, and slowly passed into the uterus with very gratifying success. Electricity may be of service. Swabbing the uterine cavity with spirits of turpentine is said to be quite efficacious.

After the hæmorrhage has been subdued, if the uterus remains open and the cavity large, an intrauterine packing of Iodoform gauze with absorbent cotton tampons placed up against the circular arteries will be a decided help in further controlling the trouble.

I am well aware that in this many able obstetricians will take exceptions, but I speak principally from personal experience, and am convinced that the tampons against the vessels aid in controlling the blood supply to the uterus and the uterine packing stimulates contractions; it must be done aseptically (as should be all such work) and the packing removed in twenty-four or forty-eight hours.

Stimulants may be called for and should be promptly used to, if possible, avoid syncope. Nourishment should be given in concentrated form, as beef tea, or beef extracts, milk, etc.; food and drinks should all be given cold; if given warm they will tend to increase hæmorrhage.

I well recall two cases of secondary hæmorrhage—the one occurred from the patient carrying a cradle down a flight of stairs, and the other, Mrs. S., left her lying-in bed on the third day to spank her boy—the lad led her a chase about the room; after the excitement she began wasting more freely, and medicines were given without avail. (I did not then know of the exciting cause). On the fifth day from confinement I was hastily summoned; the uterus was contracted so that I could not fully introduce the finger, much less the hand. I placed her across the bed and introduced the speculum, when the blood poured forth as from a hydrant. With inefficient help I douched freely with hot water and then with hot vinegar and water, packed the uerus with Iodoform gauze and cotton tampons to either side of the cervix, kept her quiet, gave nourishing diet and she made a good recovery and continues to spank the boys.

DISCUSSION.

Dr. E. W. Mercer: My experience has been, though I believe that it is not the post-partum hæmorrhage of which we read, the gushes of blood, that give me so much trouble, but rather those which are persistent from a low situation of the placenta in the lower segment of the uterus and where the sinuses are not effectively closed, probably by lack of uterine contraction producing a persistent hæmorrhage. Still they are not so alarming. The difficulty of controlling hæmorrhage is great where it is necessary to deliver a placenta prævia.

But I believe that if we are careful, particularly careful, to guard the uterus after it is empty, careful to empty the uterus when it should be emptied, not allowing a partially separated placenta to remain within the uterus, and an accumulation of blood back of it, we are very much less likely to have these post-partum hæmorrhages, and even after it is emptied guarding the uterus, making an especial point to watch the contraction afterwards.

Another thing, anteflexing the uterus by compression beneath the cervix and upon the abdominal walls, anteflexing the uterus is a very important method of controlling hæmorrhage. If the hæmorrhages are at all profuse it is necessary to control them temporarily by introducing the hand within the uterus. That may be done for a considerable time until you are prepared with your injections or packing or whatever may be necessary, and in the vast majority of cases it will not be necessary to institute further treatment than by occluding the cervix for a short time. The internally administered remedies, as distinguished from those which act mechanically, are no doubt effective. The great trouble I have always had is that I cannot get at the medicine. It is not just at hand and I do not feel that I can leave my patient to prescribe medicine.

Dr. D. S. Kistler: In order to prevent post-partum hæmorrhage, it has been valuable to me to anticipate these conditions, and I have received considerable help from Ergot. If I have a case where I have a history of post-partum hæmorrhage, a history of excessive flowing, I give Ergot. If I have a severe case of albuminuria, I give Ergot. If I have a case of pregnancy with a number of previous pregnancies within a short period of time, I think it is well to give Ergot. These are the indications from which I think I have had very good results by giving Ergot; as it has had a tendency to prevent excessive flowing after parturition, which probably would have been the case.

Dr. Frank Harpel: The first case I had of post-partum hæmorrhage made my hair stand up, notwithstanding the advice of Dr. Kline to keep cool. It came very suddenly and from the indications I had to get to work in good earnest. I had heard of injections of hot water. I happened to have my syringe and I used several quarts of hot water, as hot as it could be borne, injecting it slowly and steadily, and, at the same time, using Hamamelis (mother tincture), and I had the pleasure of finding that doing the work, and, in a short time, I controlled my hæmorrhage—the first one I ever had. I used it after that; other remedies I used with success—Ergot and Caulophyllum, but I never had anything to act as quickly as hot water and Hamamelis.

Dr. J. W. Thatcher: I was once called hastily to a case of hæmorrhage, and drove as hard as the horse could take us, a distance of two miles, and found the woman scarcely conscious; no pulse; she was vomiting and the blood was just gushing from her; her bowels moving at the same time, and she was in a perfect state of collapse. Those attacks occurred about every two hours. She was a fleshy, strong-bodied woman. Just as I walked into the room she had one of these spells, vomiting and profuse movement of the bowels, very thin and a gush that sounded like "shoo;" you could hear a very great amount of blood passing. I recognized the remedy at once—it was Ipecac. I put some Ipecac. in water and gave her a teaspoonful every half minute and gave it to her for a period of five minutes. She had another very, very small gush, and after that not another hæmorrhage and made a beautiful recovery.

The doctor spoke of giving Ergot, where he has a history of albuminuria, hæmorrhage, etc. I think it is very much more wise to take a history of the case and carefully select your indicated remedy and cure that woman before she comes to the state of hæmorrhage. I well recollect the first case I was called to when I first graduated. located up in the country where homœopathy was not known and where I could not walk out of my office but that I was scoffed at as a quack. There was a lady there with several children who had had a horrible history. She had a retained after-birth and dreaded that more than having a child, although having a child was the more horrible ordeal. After getting the case I found there was a good deal of talk, and it was generally believed after this confinement I would not be of any more use in the town; it would be my death-knell. I carefully took the history and selected the remedy, and it was Pulsatilla all the way through. She made a beautiful recovery. The

after-birth was slightly retained, but I waited awhile, gave her Pulsatilla, waited a full half hour. It came around all right and it established me. If you get a history of a case and carefully study your remedy you will cure your conditions.

Dr. John E. James: I want to emphasize two or three points that have been made in reference to these cases—first, know what is the cause. If it is something retained get rid of it. If you are going to inject be sure and get your injection of hot water into the uterus and not into the vagina alone. Any mechanical means of anteflexion is one of the most sensible things a person can use. The doctors have grabbed the cervix with one hand and the fundus with the other and tried to keep it straight; just bend them together. I will relate a case that occurred recently under my observation. I was busy with something else and allowed Dr. Lane, my colleague at the hospital, to go on with the operation and the history of the case was supposed to be a retained portion of the placenta. She had three or four attacks of hæmorrhage at child-birth three weeks before. She was having some fever, rise of temperature, peritonitis. The case was etherized, and I told him to go ahead with it and I went off to a faculty meeting or something else. He sent for me to say that things were odd. He opened the abdomen and we found everything adherent around the uterus. We could not make out where the uterus was. When we loosened the adhesions and came to the uterus we found the intestines apparently inside of the uterus. On careful examination we found a rupture of the fundus, and through that there had protruded, through the uterus, nine or ten inches of intestine, the outer walls of which had sloughed off and allowed the muscular part to stretch; and when he introduced the dull curette and fingers into the uterus after dilating it—it needed a great deal of dilating—he found that there was something like a cord hanging in it and supposed it was a retained placenta. Pulling it out it did not feel or look like the cord, so he reintroduced it, washed the parts off, packed the vagina. We loosened up the intestines and pulled them up and found that there had been a rupture and protrusion of the intestines into the uterus, and that is what caused the frequent hæmorrhages. We pulled it back and resected the bowel and removed the uterus and the adnexa. A remedy in such a case is of no use until you remedy the defect. A good many of hæmorrhages are due to some tear. I am more and more convinced that we more frequently have laceration, complete rupture or partial rupture in these labors. My attention was called to it a few years ago when Dr. Lee, of Rochester, pro-

duced a case in which he had removed the uterus and examined it. There had been odd symptoms, nervous symptoms and tenderness, so that he could not remove anything else. He removed the uterus and, opening it, found a line of cicatrix on the inside of the uterus, running in three or four directions. It had ruptured on the inside and not much on the outside; did not produce much peritonitis. How much these scars had to do in this rupture of the uterus with her nervous symptoms I do not know. But she was relieved of them. I have seen several cases in which I have found evidences of scar. I remember a case which I stitched up—a case of persistent retro-displacement with great nervous symptoms following. I found a scar running down from the fundus posteriorly almost to the cervix that had healed, with a dent on the line of the cicatrix. She had a hard time getting up, but no evidence of sepsis or of hæmorrhage, but evidently there was a rupture there. Now, I say in these cases nature may be good to us, but we ought to know by a careful examination—the finger is the best thing to examine with; your probe or sound is not half so good as your finger. It is a good thing to find out what is wrong, and then if there is anything there get it out. You have to do it quickly. But do not operate until you know what is wrong. I operated a case only two days ago. The physician was fooling with his remedies until the whole uterus became impregnated with pus and she died with septic condition before she could be operated. Give us your cases for operation before you let them become septic that we cannot do anything; we can stop re-infection.

Dr. J. W. Thatcher: I think giving large doses of Ergot is overdone by allopathists, and kills the patients. They give Ergot by the teaspoonful, and the result is death; it superinduces hæmorrhage. And probably Ergot was not the indicated remedy at all.

Dr. W. J. Martin: More than twenty-four years ago I attended my first case of obstetrics. I always take the time to go away from my patient long enough to prepare the homœopathic remedy, and depend on that, and do whatever is necessary as a secondary procedure to the homœopathic remedy. That is my way of treatment of post-partum hæmorrhage, and my result has been in twenty-four years of practice no death.

Dr. W. G. Dietz: As homœopathists we ought to know our business, and ought to know our remedies and know when and how to use them. We ought also to be confident in the use of every other means the moment that the call may require of us, and to use it

promptly. I can confirm what can be said about Ipecac. I have seen Ipecac (30th) stop hæmorrhage, gushes of blood, the patient in a cold-sweat, and stopped it in ten minutes, and the patient could be said to be out of danger. I have also seen Ipecac fail. Why? Simply because the placenta acting as a foreign body in the uterus had been overlooked. I say emphatically that to administer Ergot because you have a post-partum hæmorrhage is criminal. To remove the cause and know what you are about is absolutely necessary. Merely to give Ergot causes contraction of the uterus, clots retained, and because of the contraction of your uterine muscular structures and blocking everything up what have you? Why infection is almost certain to occur. And what are the difficulties of the case when the necessity of the case, after resorting to mechanical means to remove that which should be removed at first, are presented? In my experience, I have had one case of post-partum hæmorrhage and it was due to a tender uterus. The remedy could control, but I had to use mechanical pressure to empty the uterus thoroughly and when emptied keep it contracted, no matter how long it took to do so. It is the remedy that will do the work if the cause be removed. It is wrong to allow a case of hæmorrhage, due to a lacerated uterus, to go on I am certain that is, strictly speaking, a surgical case and should be treated on strictly surgical principles. We should make a distinction between mechanical and surgical treatment. A strictly medical case is one in which your hæmorrhage depends on causes irrespective of traumatism.

Dr. D. S. Kistler: I call to mind a case which had a previous history of extreme hæmorrhage. A woman pricked herself with a pin or needle and there would be persistent bleeding. In spite of Phosphorus that case went through her confinement with a certain degree of hæmorrhage. She again became pregnant and I prescribed Ergot. I controlled the hæmorrhage very nicely; there was very little then. Given a case where you have a history of that kind, a history of one or two persistent, severe floodings, I think we are justified in anticipating the result. There is no cause outside of this constitutional state of flooding. If you have a case of albuminuria it is good practice, it is the right practice, to try to control the albuminuric condition, get the woman in the best possible shape previous to delivery; but if in spite of your efforts you fail and find your urine is thick, the solids and urates are increased, and you have the œdematous condition, and you use instruments and have a rapid delivery, in order to deliver the case, in

that case it is good practice to use Ergot. There are two particular cases I had in mind when I made the remark I did. If after the delivery of that child five or ten grains are given, by the time the placenta is delivered the uterus will contract as a result of the Ergot.

Dr. Charles Mohr: Before a physician resorts to anything he ought to decide in his own mind the nature of the case. If a case requires only mechanical or surgical treatment, surgical treatment ought to be employed. If he can determine positively that it is a case for medicinal treatment, then medicine ought to be given and should be given according to our well known principles. Now, reference has just been made to Ergot, and it is an agent that I used in a post-partum hæmorrhage only once, and I did that at the suggestion of one of my earlier teachers. Fortunately my case recovered and I can say what Dr. Martin did, that I never lost a case of post-partum hæmorrhage. The man who taught me that I should use Ergot after twenty more years' experience said what Dr. Dietz has said, that he condemns the use of Ergot and does not think of using it now, and has not for some years.

Now, another point I think we ought to take into consideration is the fact that where you have any case in which there seems to be a tendency to excessive loss of blood, after repeated confinements, as we do find occasionally, there are cases in which at delivery or immediately after delivery of a case some medicine may be indicated for the presenting symptoms, if it is a case for medicinal treatment. We usually find that the acute-acting remedies which have been alluded to are the ones to be employed, such as Ipecacuanha and Belladonna; Aconite is another remedy which has not been mentioned, all of which I have successfully used in my practice to control these hæmorrhages. But when we get a case or study a case—I have delivered a case five or six or more times—I learn their previous disposition from various symptoms which occur during gestation. I know the history of each confinement, I know the consequences after delivery of the child and after the removal of the placenta, and then I am able in these cases to give a constitutional remedy which usually wipes out all the pre-existing causes of hæmorrhage which had been active heretofore. Therefore, we do not want these acute-acting remedies so much.

I want to call attention to the fact that Aconite has been the remedy in hæmorrhage for the acute symptoms, and that where there is a tendency to hæmorrhages in confinement the remedy is usually Phosphorus. I have found by experience that the women who, dur-

ing confinement, by reason of excessive hæmorrhage or flooding, require Belladonna require, as a constitutional remedy, Calcarea carbonica. I have found that the cases that usually require Ipecacuanha require as a constitutional remedy Kali carbonica.

The point I want to make is simply this: If you have a case in which there is a tendency to hæmorrhage or any other form of diseased conditions occurring during gestation, during labor or after labor, a study of the constitutional peculiarities will lead us surely to some medicine which is given according to the indications of homœopathic principles, and it will wipe out the causes which result in certain effects.

Dr. T. S. Dunning: I have really enjoyed this discussion and also this complete paper of Dr. Kline's. I was surprised that he made no reference to the normal salt solution—transfusion—and that is the only thing I noticed lacking. I was very glad that he called attention to the value of pressure upon the abdominal aorta. It seems to me—it may be expedient while your remedies are acting—that that is the most promising of methods for controlling hæmorrhage temporarily; first raise the feet and hips, and if we can secure firm pressure on the abdominal aorta, sufficient to control the flow, just as we would exert pressure there in an operation upon the upper thigh, so as to prevent absolutely an excessive pressure of blood on those parts,—if we can thus secure firm pressure we can expect to control the hæmorrhage, even if it occurs from rupture of the uterus; and it gives us time for remedies to act; or, on the other hand, it gives time for the clot to form.

Dr. A. P. Bowie: I think that post-partum hæmorrhage prevention is better than cure in that trouble as well as in some other things. and I think the old-fashioned way the old-fashioned homœopath used to do after each case of labor to give Arnica, not in the tincture, but in the potentized form, will prevent a good deal of trouble, not only hæmorrhage, but other troubles that we have. The remedies I have found most useful in post-partum hæmorrhage are Belladonna and Secale. I do not think it is necessary to use Ergot in tincture form homœopathically. I always used it in the potentized form, say, the sixth dilution. If the remedy is needed you get results from that that are satisfactory and you do not run any risk of doing your patients harm. I am satisfied that the use of Ergot in the tincture form is baneful in many cases, and I do not see why a homœopathic physician has ever to use teaspoonful doses of it.

Dr. R. P. Mercer: Hamamelis is certainly worthy of study among our physicians.

Dr. J. H. Sandel: Where there is a history of excessive hæmorrhage, especially in cases where the second stage of labor is short and has been short in a succession of confinements, do everything you can to retard the second stage of labor. My theory in that is to exercise the uterus naturally. You know, by experience, that where the second stage of labor is very brief the tendency to hæmorrhage is greater. In one case especially which I had the woman had been confined eleven times. The first two times I attended her I had considerable trouble with hæmorrhage. The last time I did everything to retard the second stage of labor, had her to make as little effort as possible and did everything that I could to retard that stage. The placenta was then delivered naturally and readily and we had smooth sailing all the way through.

Dr. Robert Murdock: It has been twenty-eight years since I had my first case of confinement and I never lost a case of post-partum hæmorrhage, or did I ever resort to any hot water means. I have always depended strictly on the homœopathic remedy.

Dr. D. C. Kline: I think in some of these cases that are predisposed to hæmorrhage we fail to take the precautions that we should. A woman under my care had been confined three times, and in two of these confinements had had a terrific hæmorrhage. Knowing the patient for but a short time previous to confinement, I found that she was one of those women who could not keep quiet, and I concluded that one difficulty was she would not keep quiet and help these hæmorrhages. I gave her a little talk. I told her I should insist on her keeping quiet. At the time of her confinement I said she must sit down and stay quiet until I gave her permission to move. Her deliveries were quick, and before I could get to the house the baby was born. When I got there she was perfectly quiet and cool. This was preparatory treatment and she had not a sign of a hæmorrhage. That avoided a hæmorrhage. After her former confinements she would rise up in bed, attempt to take care of the child, and then there would be a hæmorrhage. We had a child this time and no hæmorrhage.

Another woman delivered the fourth time got through all right, but in this child she had a babe with a cleft palate. I motioned the woman to the side and bade her keep quiet, but unfortunately she did not have much gumption and in a very few moments I heard: "What's

the matter with the baby?" I said: "Nothing; attend to your affairs." Even with that I could not keep her quiet. "What is the trouble, doctor? There is something wrong." I was about to leave the room, when suddenly I turned to look at her and there was a deathly pallor. I examined her and there was a continuous gush. There was a case that I don't think any of us could avoid—I could not avoid it. I did not know that the baby was going to have a cleft palate.

INFLUENCE OF NEURASTHENIA ON PREGNANCY AND PARTURITION.

E. T. SCHREINER, M. D., PHILADELPHIA.

MANY neurotic women are attractive and interesting from just the causes which make them neurasthenics, viz., sensitiveness to nerve impressions and quick and intense response to nerve stimulation. These women are in greater demand matrimonially than those of more phlegmatic temperaments, and the rearing of their progeny into normal men and women instead of bundles of nerves is, at the present day, one of the most prominent tasks of all physicians. I do not propose now to enter this broad field, but only to consider the symptoms which we may meet, and the methods we may use to overcome temperamental weakness at that epoch in a woman's life when she is most liable to seek care and to accept advice. In the majority of cases the pregnant condition has a quieting effect upon the nerves, and, unless the patient is very weak, tends to her physical improvement. Where the opposite condition is present, and the nerves are irritated, only extreme care can avert abortion. By extreme care is not meant of necessity keeping the patient in bed, but removing every possible source of irritation. Physical exertion must be avoided, but more especially all sorts of nerve excitants, such as tea, coffee and stimulants, exciting conversation and literature, sexual indulgence, hot or cold baths, social functions in over-heated or brightly lighted rooms, fast driving, etc. We may rack our brains to think of all the things a patient of this sort should not do and she will probably think of something a little worse than any we have mentioned and do it and abort, in spite of our best efforts and hers also, as she will assure us she has been careful to do just as we directed. Positive orders must accompany the negative. There must be open air life. Not a short walk every

day, but three to six hours every day in the open air, and do not believe that this is impossible unless there is no roof on her house, as well as no ground around it. The open air life will promote sleep, of which the more the better, if obtained by natural means. Warm baths must be frequent. See that there is no irritation from improper clothing, improper food or unnatural evacuations, and be watchful to correct with the proper remedy any untoward symptom as it arises. Where the patient feels better than usual during pregnancy she would be safe enough did she not presume upon her increased strength and attempt to do things which heretofore have been beyond her. To such the advice should be, keep well within your former litimations, and let the extra strength accumulate for the benefit of the child which is coming. The intense suffering of this class of patients from gastric irritability is best met with hygenic measures, and medicine administered only in rare and attenuated doses when it is homœopathic to the case. Instrumental aid in labor should be rendered early in neurasthenic cases.

If the labor is not markedly short and easy forceps should be used with an anæsthetic, and prompt delivery be effected. A severe laceration is better than a prolonged labor, provided said laceration is promptly and perfectly repaired. The tissues of neurotic women are usually as quick in healing as they are to suffer injury. The advent of a much desired son or daughter is extremely exciting, and during the first weeks the less there is said about it the better. We must harden our hearts for the good of the patient. Just say, "The baby has nothing the matter with it," and exclude all congratulations. The best occupation for the new mother will be to find out for herself, one at a time, the baby's perfections. No letters of congratulations or letters to the infant should be brought into the lying-in room until two weeks after the delivery of this excitable person; and, of course, no visitors unless it be some one—not quite a relative—who has a soothing and quieting effect upon the patient. The same quiet vegetative existence advised during pregnancy should be continued, and unless it can be secured in an unusual degree the neurotic woman should not nurse her baby.

DISCUSSION.

Dr. Charles Mohr: The neurasthenics, as a rule, get too many medicines; they get too many tonics, and get too many so-called

homœopathic medicines in small doses. Whenever I find a neurasthenic patient—I do not care whether it is a girl, a boy, a young man, or a young woman, whether pregnant or not—I give some sort of advice as Dr. Schreiner gives. They want some kind of treatment, hygienic rather than medicinal, and if they think they should have medicines because of certain manifestations, I usually give them some placebo and tell them to do this exercise and vegetate and then they get better. So long as you keep them pestered with medicines—I do not care whether you give them potencies or not—you are going to do no good.

DISEASES THAT ARE BENEFITED OR AGGRAVATED BY PREGNANCY.

ANNA JOHNSTON, M. D., PITTSBURG.

ANTOINE PETTIT says: "Pregnancy exposes women to various disorders, arrests the progress of others, and sometimes even cures those with which they were previously afflicted;" but literature seems to be very scant on the subject of those diseases benefited by gestation.

After much research I was able to find but a few conditions which are really benefited. The first of these is dysmenorrhœa from a pinhole os, then the same trouble resulting from flexions ante or retro, providing no adhesions have formed.

Ovaritis is thought by some to be relieved as the ovaries, by not having to perform their functions during gestation, are given the opportunity to recover from their inflamed condition. One of our physicians a number of years ago reported a case of a large ovarian tumor of a cystic nature, that had been in existence several years, which entirely disappeared after parturition.

Neurasthenia was another condition thought by some to be benefited by pregnancy. With these few conditions which may be benefited we pass on to the many that may be aggravated.

First, fevers—intermittent. About this disease there seems to be some disagreement among the various writers on the subject, but the majority conclude that pregnancy aggravates it.

The chronic condition becomes acute, while in some cases the disease continues during the full term, though it may abate before de-

livery, only to return during convalescence; but more often if the attack is severe the woman aborts. Pregnancy and the puerperal condition seem to predispose those who have had malaria to this disease.

Typhoid fever may attack woman at any period of pregnancy, but occurs more frequently during the first than the last months. It often causes abortion, which may take place the first or second week of the fever. In a report of 322 cases, 140 were carried to term.

The danger to the fœtus takes place when the fever reaches 104°. Thus while the prognosis for the child is grave, that of the mother is better, although it depends on the abortion and consequent hæmorrhage.

Scarlet fever, while rare among pregnant women, yet when it does attack them, assumes the malignant type, terminating in abortion and death in the majority of cases.

Measles is also of rare occurrence in pregnant women, but Leveret says it equals in gravity the other eruptive diseases. Charpentier says that it may predispose to the death of the fœtus, and cause abortion, yet it does not endanger the life of the mother.

In smallpox the condition of pregnancy makes the prognosis very grave.

Jobard distinguishes three forms of this disease. The first, varioloid, being benign, is not so serious.

In the second, discrete varioloid, abortion is more frequent, but the mother generally recovers.

In the third, or confluent variety, abortion is the result followed by the death of the mother in the majority of cases.

Erysipelas may attack pregnant women, at least pregnancy does not render them immune from it.

The mother may, as in smallpox, abort, die, or be cured; it all depends on the gravity of the case. The life of the child depends on the height of the fever, but this is a less serious disease than smallpox; it may be regarded in about the light of measles.

In epidemic diseases we might mention grippe. Pregnant women seem to be affected more profoundly with this disease, and numerous abortions take place either as a result of the disease itself weakening the body, or from the violent paroxysms of coughing.

In cholera pregnancy seems to aggravate the disease, as invariably if the patient is able to recover from this malady abortion generally

takes place; this in the already weakened condition of the patient in many instances proves fatal.

Pulmonary diseases during gestation react seriously on the patient.

Pneumonia, as it comes from a chill, may occur at any time during this condition. Pregnancy causes an especial aggravation of the symptoms; fever marked, pulse rapid, respiration disturbed; but the case may be slight or severe. If slight, and uterine contractions absent, resolution takes place rapidly. If severe, abortion follows, pulmonary lesions are aggravated, extending over both lungs, and death follows in from two to six days.

Pleurisy, contrary to pneumonia, is seldom found complicated with pregnancy, nor is it influenced much by it. Prognosis generally favorable to both mother and child.

Phthisis.—This disease is one about which there is a great difference of opinion. Some scientists say that in this disease pregnancy checks its development, or arrests its course after it has already begun. Some that pregnancy accelerates its course or progress, others that pregnancy really aggravates the disease, but the latter undergoes marked amelioration during the early months; and still others that pregnancy sometimes interrupts, and seems to arrest the course of the disease, sometimes, on the contrary, it aggravates and hastens it.

We may conclude, then, that pregnancy does exercise a marked influence on phthisis. Another writer on this subject says: "This influence will be so much more injurious if this afferent cause is combined with other predisposing ones, such as heredity, malnutrition, bad hygiene, exposure to cold, hard labor, scrofula, pre-existing pleurisy, repeated pregnancy," etc.

Libert has presented the following statistics showing duration of disease:

Death occurred in 2% within 3 months, 20% in 6 months, 44% from 6 months to 1 year, 24% between 1 year and 6 years. Influence of pregnancy most marked on the tuberculosis between ages of 20 and 30 years. He also deducts the following:

1st, Latent tuberculosis in young girls most often appears after marriage as a result of pregnancy, either the first or a subsequent one.

2d, In exceptional cases the health of tuberculous women is not affected by even repeated pregnancies; in some instances the children are feeble, dying early.

3d, Advanced phthisis usually prevents conception, incipient phthisis does not prevent it and the pregnancy goes on to full term.

4th, Abortion, pregnancy, and the puerperal state determine the development of phthisis in at least three-fourths of the cases.

5th, Children born of a phthisical mother are generally feeble, often become first scrofulous, then tuberculous.

Heart Disease.—Pregnancy is one of the causes which hasten the progress of heart diseases, the phenomena of which develop more or less rapidly under its influence. This effect may, however, be transient, and then the valvular lesion or myocarditis does not become severe, but repeated pregnancies do cause their aggravation, hence pregnancy hastens the course of cardiac lesions, predisposes to pulmonary congestion and embolism, or may result in metrorrhagia, abortion or premature delivery.

Diseases of the Kidneys.—Albumnuria or Bright's disease is seriously influenced by the puerperal state, for during this period there is a marked sympathy between the kidneys and uterus. So when we have renal lesions existing before pregnancy, although they may not have been suspected, when under the influence of this condition, may develop very rapidly, and in a short time become incurable. When the renal lesion advances with pregnancy it rarely attains a serious stage during first gestation. The patient may die in eclampsia, but if she lives the œdema may disappear, the albumen cease to be found in the urine, and she will enjoy perfect health until the next pregnancy; this time she may improve more slowly, and so on after each succeeding pregnancy until she is exposed to all the complications of granular kidneys.

Icterus has been known to prove very fatal to pregnant women. There are records of severe epidemics of this disease among pregnant women alone in which it assumed a grave form.

One author tells us that this disease may appear as an epidemic among pregnant women, assuming one of three forms:—

1st, Simple or benign in character, allowing pregnancy to progress favorably.

2d, To cause abortion or premature delivery without any other unfavorable complications.

3d, It assumes all the grave form of icterus, producing ataxic symptoms, and coma, which shortly terminate both the lives of mother and child.

Syphilis may have a disastrous effect upon the course of gestation, resulting in abortion or premature labor; but the influence of pregnancy in this disease is manifested in two ways, either locally or

generally, and both chancres or syphilides are subject to the disturbing circulatory effects which exist in the pregnant woman, and which result in active or passive congestion.

One writer says that pregnancy complicates the pox by adding to it its own anæmia, its depressing influence, its neuralgic tendency, disorders of nutrition, etc.

As regards local manifestations, pregnancy causes the chancre to remain about 2 months and 20 days, while in the non-pregnant woman its duration is 4 or 5 weeks.

Syphilitic ulcers are quite frequent in pregnant woman, and it is usually difficult to cause them to cicatrize before delivery.

This disease may have been in the system before conception, if so there is a predisposition to abort.

If syphilis and conception are concomitant, abortion or premature delivery are the rule. If contracted the fourth or fifth month of pregnancy, the danger is less, but if not contracted until at the termination, the danger is almost nothing, but one writer in summing up this condition says that even latent syphilis is liable to cause abortion.

Lead Poisoning.—Women exposed to this trouble, if they become pregnant, are almost sure to abort, as are also those working in tobacco factories.

Hysteria and Epilepsy.—Authors differ in their opinions on the influence of pregnancy on these diseases. Many advocate it in hysteria, thinking that the hysterical attacks are relieved by gestation, while others, to the contrary, believe that not only does it fail to relieve, but that the attacks at the beginning of pregnancy become more severe and frequent, yet they generally disappear during the latter months.

As to epilepsy, the general opinion is that it is frequent during parturition, although sometimes pregnancy diminishes the frequency of the attacks, and sometimes increases them. It may modify them by postponing the attacks and rendering them less severe, and then again it exerts an aggravating influence, causing the death of the patient.

Goitre, as we know, is much more frequently found in women than in men, but it was Pettit who was the first to note its influence on the puerperal state. While it does not usually cause serious trouble, yet in some instances it assumes grave conditions.

Ollivier recognizes three distinct forms:

1st, Sub-acute or transient goitre, which develops slowly, seldom reaching a large size, often being unrecognized during first preg-

nancy. No pulsation present, health not affected and disappears almost entirely after delivery.

2d, Acute and grave goitre, which develops rapidly, gives rise to suffocation, and death may ensue from asphyxia, or suppuration may take place.

3d, Chronic Goitre.—Sometimes the enlargement appears during pregnancy, remains stationary after delivery, or even undergoes a slight increase in size at each successive pregnancy. Sometimes the acute form becomes chronic, or the goitre is only recognized after delivery, or chronic goitre may pursue its course in the gravid woman until a more or less advanced stage of pregnancy, when it will rapidly enlarge so as to compress the trachea and cause suffocation.

Traumatism.—Pregnancy, as a rule, does not exert any injurious influence on traumatism. Thus wounds, contusions and fractures are not followed by any higher mortality in pregnant women than in other individuals, and cure of such injuries takes place in the usual manner.

The exceptions to this are: 1st, When the injury affects the genital tract. It may be rendered milder, complicated in its course, or its termination be delayed by the existence of pregnancy. This is true even after the third month of gestation, provided that the injury affects the lower limbs, or in a region in which vascular changes have taken place.

And now, in conclusion, I think on summing this all up we find the conditions or diseases benefited by pregnancy are few, while almost all are aggravated; hence, we should hesitate before advising marriage and pregnancy to those who are abnormal in their various functions, lest we may make ourselves responsible for wrecked lives, or perhaps human beings who may have to drag out a miserable existence on account of the unsoundness of her who bore them.

REPORT OF THE

SECTION OF GYNÆCOLOGY.

Extra-peritoneal Hæmatocele; A Report of Three Cases, by James H. Thompson, M. D.

Abdominal Sections, by John E. James, M. D.

EXTRA-PERITONEAL HÆMATOCELE; A REPORT OF THREE CASES.

JAMES H. THOMPSON, M. D., PITTSBURG.

On reviewing the progress of gynæcology during the past two decades one cannot but be impressed by the prominence given to surgical methods in the treatment of the diseases of women. It is doubtless true that many a life has been sacrificed and much needless mutilation inflicted by unskilled operators, and those who consider the knife as the sovereign remedy for a majority of the affections of the female genital tract.

To such an extent has the fad grown that in late years many an emphatic protest has been uttered by conservative gynæcologists against the practice of indiscriminate operating. Slowly but surely a reaction is setting in, and the day is not far distant when gynæcological surgery will be restored to its proper position. That the undue predominance of surgical procedures in the treatment of gynæcological cases has acted to the detriment of the medical profession can be easily understood, for the laity is quick to accept any prevailing fad, and many a patient has sought the service of the unexperienced gynæcological surgeon who could have been treated more successfully by her medical attendant.

As civilization advances, as progress is made in the emancipation of women and the equalization of the sexes, the gynæcological surgeon is more frequently consulted regarding certain diseases of the female sex than was the case formerly, when ignorance and false modesty held sway and women suffered in silence.

Of the causes that have been responsible for the decline of medical methods in the treatment of gynæcological cases, the chief one has been that the remedies at the disposal of the practitioner have been unreliable, if not absolutely ineffective. In other words, medical treatment has been unsuccessful in many cases, not because it was unsuitable, but because it had not been established on a rational scientific basis, as that of surgery. It will be the aim of my essay to show that medical treatment, as well as that of surgery, has a wide range of utility in the management of a large number of cases of extra-peritoneal hæmatocele, and to place before the profession a line of treatment which has already demonstrated its efficiency in the practice of numerous surgeons of our country, as well as abroad.

The effusion of blood into the connective tissue of the pelvis has been called extra-peritoneal hæmatoma, thrombus of the broad ligament, and pseudo hæmatocele. Some writers have denied its existence outside of the puerperal state, in which thrombus of the vagina and vulva may also be produced, but at the present day its existence is acknowledged. The same causes responsible for the intra-peritoneal variety of hæmatocele are quite as often responsible for an effusion of blood into the subjacent cellular tissue; as already intimated, the accident frequently follows salpingotomies and ovariotomies. It is probable, too, that this form of hæmatocele is often due to extra-uterine pregnancy than is the intra-peritoneal variety. It may be produced by the influence of pregnancy, as we know that it causes a dilatation of the entire pelvic venous system, especially of the utero-ovarian plexus, but utero-ovarian varicocele may exist and cause a sub-serous rupture even outside of pregnancy. It is usually observed as a result of over-work or sexual excesses during the menstrual period, in multiparæ whose veins are more dilated than those of women who have never had children.

According to Byrne, thrombus of the broad ligament is more frequent than is usually admitted, and may often cause pelvic abscess or phlegmon. As regards the relative frequency of the two forms, there exists a difference of opinion among the authorities owing to the fact that intra-peritoneal hæmatocele is oftener fatal. The older writers, because of this fact, believe the latter to be by all odds the more frequent form. Abdominal surgery has thrown new light upon the subject. We know when the blood is limited by the peritoneum death rarely, if ever, occurs. There are many cases of extra-uterine pregnancy which rupture into the folds of the broad ligament, giving

rise to an extra-peritoneal hæmatocele which are followed by fœtal death absorption and recovery. Some idea of the size of the tumor and the resulting changes can be obtained when it is stated that it varies in size from that of a fist to that of a man's head.

The blood may form a circumscribed tumor between the folds of the broad ligament, which, not being a closed cavity, but communicating with the pelvic cellular tissue, permits of an escape of the blood if it be abundant, when the effusion is directed toward the vagina and rectum, and carries the cul-de-sac of Douglas to the bottom of the pelvic floor. If limited to one side, the uterus is pushed to the opposite one, if both sides are implicated, the tumor is usually much greater on one side than on the other. The two tumors may unite in front and back of the uterus. The pressure upon the rectum and bladder is sometimes so great as to cause retention of urine and prevent a free action of the bowels. This accident usually occurs to women who are apparently in a healthy condition. Owing to the fact that the quantity of effusion is limited by the investing peritoneum, the symptoms are not usually so marked as in the intra-peritoneal variety.

Beigel believes that extra-peritoneal hæmatocele constitutes a considerable portion of cases usually classified under the more ordinary form.

The patient is first seized with a sharp pain in the lower part of the abdomen, with a tendency to syncope. There may, however, be successive attacks. The symptoms of profound anæmia and troubles due to compression of the bladder and rectum are manifested, together with swelling and tenderness of the abdomen.

By bimanual palpation we feel that the tumor is in one or both broad ligaments, usually in one only, and not in the cul-de-sac of Douglas, and it is soft and pasty. The uterus instead of being in the centre or to the front of the tumor, as in the intra-peritoneal variety, is pushed to one side. It is at first soft, becomes more condensed as time progresses, and in the event of suppuration again becomes soft. As to the other symptoms and the course of the disease, they are the same as those given for intra-peritoneal hæmatocele.

One special symptom, ecchymotic spots of the vagina and abdominal wall, has been observed, and belongs chiefly to the extra-peritoneal hæmatocele. The differential diagnosis between the two cannot always be made. It must be based upon the etiology and the lateral situation of the tumor and its relations to adjacent organs.

Expectant treatment is the rule. The physician should always direct his attention to the shock and syncope when these symptoms threaten life. Place your patient in bed as quickly as possible. Cold applications should be applied over the lower part of the abdomen, with hot ones to the extremities, and if shock is at all marked stimulants should be resorted to, using hypodermic injections of Strychnine, Nitroglycerine, brandy or Sulphuric ether. Saline solution may be used advantageously by throwing it into the rectum and the indicated remedy administered internally. If the hæmorrhage proceeds from a large vessel any form of internal medication will be useless, and too much time should not be wasted in temporizing. If the gravity of the symptoms calls for interference, operate as soon as the diagnosis is made. We cannot do a vaginal operation because of the danger of wounding a large vessel of the uterus. Sub-peritoneal laparotomy seems to me to be the best operation. Martin recommends trans-peritoneal laparotomy, with cleansing of the cavity and suture of the wound over a T-tube, which emerges through the vagina. In the event of suppuration, it is, of course, the duty of the physician to treat the case as one of pelvic abscess. On the other hand, as long as the case progresses favorably, the tumor gradually becoming smaller, the pressure symptom growing less and less severe, the peritonitis disappearing, the physician's duty is to leave well enough alone and watch for alarming developments and avert them if possible by judicious treatment.

Burton speaks very highly of the use of electricity in promoting absorption of hæmatocele. The patient is kept quiet in bed, and a galvanic current applied over the back and front, or the negative pole directly within the vagina. Begin with a current of ten milliamperes, gradually increasing it to one of fifty milliamperes.

A few surgeons advocate evacuation of the hematic tumor if it does not grow smaller in a month, even though no evidence of suppuration exists. A few prefer the vaginal operation to laparotomy, and others advocate rectal section. Kroske recommends the sacral method.

Case I. Mrs. G. N., aet. forty-three, married, no children. General health has always been excellent. June 10th, 1900, she slipped and fell from a motor car. From what I ascertained, I concluded that in falling she had struck upon the pavement directly upon the sacrum. She was carried into a nearby drug store, being rendered unconscious by the fall, but regained consciousness in a few moments and gave

orders that she should be taken home, where I saw her shortly after the accident suffering from severe shock. She complained of sharp pain in the lower part of abdomen, nausea, and with a tendency to syncope. She was greatly distressed by the pressure upon the bladder and rectum. Upon an examination, found a tumor the size of a double fist in the left broad ligament. The uterus, instead of being in the centre, was pushed to one side. The tumor was quite soft, my diagnosis being an extra-peritoneal hæmatocele. Had all clothing removed and patient in bed as quickly as possible. Applied ice bag over lower part of abdomen, and heat to extremities, stimulated by hypodermic injection of Strychnine and brandy. A quart of normal salt solution was thrown into the rectum. The indicated remedy administered internally. My duties as a physician being fulfilled, departed, leaving orders with a competent nurse to watch for alarming developments, and report or avert them if it was in her power to do so.

She progressed to a rapid and complete recovery without a complication, except a slight attack of peritonitis, which lasted about three days, at no time causing a temperature over 101°. The tumor at first was soft, becoming more condensed as time progressed, and later becoming soft and completely disappearing at the end of six weeks.

Case II. Mrs. E. L., aet. thirty-eight, married, one child. General health had always been good. March 12th, 1898, fell from a step-ladder while hanging curtains. At the time suffered no inconvenience more than experienced a sharp pain in right ovarian region, with a sensation of something giving away. I saw her some three days after the fall, and found her complaining of the usual chain of symptoms as described under Case I. Her prominent symptom was severe pain in lower part of abdomen, chills, and with a pulse of 110 and temperature 102½. After having made my diagnosis of an extra-peritoneal hæmatocele of right side prescribed the usual course of treatment, and awaited developments. At the end of two weeks found a point of fluctuation over the seat of tumor within the vagina, with all marked indications of suppuration. The tumor pointing into the vagina the vaginal operation was preferred. On opening the tumor, about a quart of sanguineous pus escaped. A T drainage tube was inserted, held in place by a strip of iodoform gauze loosely packed about it. The cavity was daily washed with an antiseptic solution.

She made a complete and uneventful recovery in a fortnight after the operation.

Case III. Mrs. T. H., aet. thirty-four, widow, always enjoyed the best of health. April 4th, 1899, upon moving a heavy dresser about the room felt something giving away in lower part of abdomen, bringing on a slight menstrual flow. I saw her four days after the accident, and in making an examination discovered a good-sized tumor of the right broad ligament, with all symptoms present as described above. Diagnosed her case as one of extra-peritoneal hæmatocele.

She was ordered to bed, and the usual course of treatment prescribed, and in three weeks the tumor had completely disappeared.

Finally, in summarizing, I may say as follows:—

(1) In all cases of intra-peritoneal rupture operate as soon as the diagnosis is made; do not wait for reaction to occur. Support such patients before and during the operation by application of heat to the extremities and back, transfusion of decinormal saline solution, rectal use of beef tea and saline solution, and Strychnine, Nitroglycerine, brandy and Digitalin by hypodermic injection. (2) If the hæmorrhagic blood cannot be quickly removed, let it alone and use drainage through the vagina. Do not flush the abdominal cavity to remove blood. The peritoneum will absorb the blood with much less danger than is caused by such manipulation. (3) Use silkworm gut *en masse* to close the abdominal wound in case there has been great loss of blood, as the buried animal suture is not really absorbed when such depletion has occurred. (4) Extra-peritoneal hæmatocele caused by ectopic pregnancy is usually self-limiting and will almost always result in the death of the fœtus and the recovery of the patient. (5) In cases that go on to full term operate at the end of pregnancy to save the child. Operate through the abdomen, drain through the vagina, and leave the placenta to come away by disintegration. (6) Electricity should be used only in cases so situated as to preclude the possibility of securing proper surgical treatment.

DISCUSSION.

Dr. E. W. Mercer: Just one point; the doctor makes a remark in closing that the hæmorrhages from hæmatocele, from ectopic pregnancy, are generally self-limiting and generally take care of themselves. In these cases, if you allow nature to have her way, the mortality is about 66 per cent. and in cases operated 5 per cent. Now I cannot quite agree with that point there and it has been my ex-

perience with those cases that they are not self-limiting and these primary hæmorrhages may not result fatally. We may have a second hæmorrhage which will result fatally, and if death does not occur as a direct result of hæmorrhage we are very apt to have septic conditions develop and death as a result of that.

Dr. R. E. Tomlin: I was surprised by some things spoken of by the essayist of this paper, and I am inclined to agree with Dr. Mercer, whose paper was practically on the same subject. Cases of this kind that I have seen and assisted in, and the latest literature which has been at my disposal, resulted in just the opposite way from that mentioned in the paper, and particularly the second case, where no hæmorrhage ought to have resulted, and septic infection occurred, and an abscess which depleted the system of its vitality and rendered death a likely result. Still the doctor's cases all recovered. If the end justifies the means well and good. The subject is interesting, and I personally believe from what I have seen and what little knowledge I have that lots of cases die that ought to live and would live if immediate procedures are carried out, such as are suggested by Dr. Mercer.

Dr. J. E. James: I surmise from this paper that we have evidence of traumatic hæmorrhage beneath the broad ligament; in Dr. Mercer's case we had ectopic pregnancy; there is no doubt that the general principles of surgery must apply to traumatic hæmorrhage anywhere. If it is being aborted by nature, you can wait. If nature stops a little, go the other way quickly; get rid of it as quickly as you can. There is a danger of hæmorrhage being extra-peritoneal, the cause of which is not quite so certain. That has not been touched upon by author or writer, and I do not propose to go into it.

ABDOMINAL SECTIONS.

JOHN E. JAMES, M. D., PHILADELPHIA.

I do not propose to inflict on you a two hours' lecture on abdominal section or laparotomy. There are some points about it that induce me to take this subject. In the first place, the patients that come to us from physicians come with such strange notions and with such horrible ideas and sometimes with such instructions from their doctors that make me possibly a little shaky on the subject of these abdominal sections in severe cases. In the first place, it is a poor plan to send

a patient to the city or to an operator with the idea that it is the last thing that can be done, and that they are brought there to die. Most of them who come from a distance come down with the idea, "Well, I am going home a corpse." It is not a good beginning for a serious operation that is going to be a tax on the patient, and my advice to the doctor is not to make the diagnosis so positive and explain to the patient what they are going to go through. Leave that to the operator; he probably has more experience and knows how to handle cases and how to do it. But if they come down with their hope all gone it is difficult to get them in the condition in which they need to be to bring them through that serious operation. That is my first thought.

As to the complications that occur, or at least the things that do occur after these serious operations on the abdomen, the first is shock. Shock is induced either by prolonged anæsthesia, which frequently cannot be avoided, prolonged operations, which sometimes cannot be avoided, unnecessary exposing and handling of the intestines, which also cannot always be avoided; these induce shock. Of course, there is another condition that we always anticipate and expect with shock, and that is great loss of blood, great hæmorrhage, which always put us on our guard for a great amount of shock.

Fortunately we have a remedy for that, and I think most operators are ready to anticipate shock in such cases, and the helping of the system by introducing a substitute for the loss of blood—saline infusion, whether in the veins, which is commonly and quickly done, or if the abdomen is opened by leaving it in there or by putting it in the connective tissue. In women the easiest, quickest and safest place is under the mammary glands. A free solution of saline—normal salt—solution will act very well in shock from hæmorrhage, but it does not always do for shock coming from other conditions. It may assist the ordinary, usual remedies and conditions for stimulating if patients generally have to be indulged in for the other conditions. One of the annoying symptoms we have after these operations is vomiting. If the patients who are sent down could be dieted before being sent to us, some regulation away from a coarse diet, not necessarily restricted too much, but restricted in the quality rather than the quantity, until they can get the nervous and digestive system in good condition, it helps us. Patients do not like to stay in the hospital while we are getting them ready for operation, but there is no doubt that the preparatory condition and treatment of the patient on

the line of diet favors not only their comfort, but avoids these complications. We expect more or less vomiting, but that which occurs immediately after an operation, or a few hours or a day or two, means nothing but discomfort to the patient as a rule. That which recurs after the first has ceased, especially if associated with other symptoms, such as tenderness and pain, rapid and irritable pulse, or erratic temperature, means something more serious, generally a peritonitis, which may be suppurative or not; but the first vomiting can be avoided by having the patient in good condition when sent to us; if we have the chance of treating them long enough beforehand we can avoid it. But you can help a good deal when you are sending the patient to the surgeon. The pulse is a great reliance; we depend upon the rapidity and regularity of the pulse, and yet you will find a good many of these cases—and when we can see the doctor we can get the history and sometimes not—but when you find the patient with an irregular or distinctly atypical pulse, a patient with a normal, high pulse, a patient with a normal, low pulse, a patient with a normal (I was going to say), intermittent pulse, but a long-continued intermittent pulse without organic lesion, it is a great comfort to us to know it, and it helps us to hope for getting the patient through. At times it makes us a little more heroic before the operation. If it is abnormal we know what to do with it. We learn to pay not a great deal of attention to the temperature, except to watch it carefully, but when you have a sub-normal temperature, with high pulse, it makes our hair stand up, or very high temperature and very rapid pulse which produces anxiety and gives unfavorable prognosis —gives us a condition of things that makes us uneasy and an unfavorable prognosis. A temperature that runs a little above normal —one hundred to one hundred and one—two or three days after an operation is nothing abnormal. A great many patients run up to one hundred, or ninety-nine, but as long as it goes up slowly for a day or two and goes down again it does not mean anything, shows an irritable condition from some condition in the operation or the action of some product of a germ or some error in the diet, but it is comparatively harmless. But a temperature that goes up after that, suddenly jumps up, or that suddenly goes down, if it suddenly jumps up and becomes erratic, with a peculiar expression of the face and breathing and irregular, rapid pulse, means the beginning of a serious peritonitis, especially if constipation exists. On the other hand, if the temperature is up and the pulse down, or the reverse, the

pulse up and the temperature away down, we find that the same condition of collapse means probably hæmorrhage. Tympanites is another symptom. If temporary you can relieve it by using the colon tube high enough in the bowels through the rectum. If that fails, the use of an injection and enema that will bring about a movement; or if that fails, the use of a cathartic for the purpose of bringing on a movement of the bowels, will remedy your tympanites.

I want to say this: I am not in favor of the constant use of turpentine stupes. We generally can get along without them. Pain is a common symptom and one for which the patient should not as a rule be put under the influence of morphia. I do not believe in faith cure or Christian Science for overcoming pain, but nevertheless patients sometimes can be induced to bear the usual pain that follows any cutting operation instead of flying to the use of morphia. I only use it in extreme cases. I will not allow my patient to suffer unnecessarily, but in these cases we want to get restored to us as quickly as possible the normal condition and the shock of the operation interferes with the action of the kidneys. Always ascertain the quantity of urine passed; the kidneys slow down and in some cases all the urine will be stopped for some hours by a dose of morphia. The same thing with the bowels; you get peristaltic motion of the bowel interfered with by the morphia, which is also a result of the operation. So I avoid morphia wherever possible, except in cases where the patients have been morphia-users beforehand, and then they are cases similar to alcohol-users. Of itself I avoid it, and usually a little talk will help the patient. If a remedy has to be used I would like it to be given so as to put as little into the stomach as possible; put it in a tablet or powder so as not to put much into the stomach. Sluggishness of the bowels is one of our serious troubles, or paralysis, as it is sometimes called. That condition is always present; it is the symptom that frequently precedes serious peritonitis following operative procedures. It is one of the things to be dreaded, overcome and avoided, and here I think, taking a little exception in my practice to a great many others, looking over the subject of authorities, as to their views, I find they vary—a great many advise to do nothing with the bowels until three or four days. It is time enough for a movement of the bowels three days after operation. But my almost invariable rule after these cases is to overcome this sluggishness and this tendency to paralysis and bring about a restoration of the normal action of the bowels and of the kidneys by the use of a cathartic

within twenty-four hours after the operation. My rule is to use a quarter of a grain of calomel every hour, beginning about sixteen or eighteen hours after the operation, and following that we use an enema—a turpentine enema is a very good one—or an enema of salt water, or a large one of soap and water. If I have an over-action of the bowels and have to stop them I do not use a large quantity; I use an enema small in quantity to work through the rectum and distend the bowels less. I get a good, free passage and return of peristalsis downward and a free government of gas, and then I feel it is pretty safe; I have gotten rid of all the complications and drawbacks of the operation. We are now ready for anything else that may come in the line of operation or of serious work that we could not overcome, such as a resulting peritonitis or inflammatory conditions, due to the want of an aseptic condition or want of proper cleaning of the abdomen of all tissue: it is sometimes impossible to get rid of all, but I mean cleaning of all the other parts.

Another point is the diet. Some patients after a very successful operation is done are very greatly disappointed that they cannot have anything to eat—that stricture is put upon them for the first two or three days—and especially that they cannot see their friends, those who come to stay with them. They are the complications that retard the results of cure; the almost impossible persistency and longing of the friends or someone else to see the patient within the first three or four or five days. Absolute rest, freedom from any visitors is absolutely necessary, and then absolute freedom from anything taken into the stomach until I have gotten nature's assistance in the movement of the bowels downward. I allow them a little water—a teaspoonful of water—but, if they prefer it, tea. As soon as I get enough peristalsis to have a passage of gas through the rectum I never allow anything else, but if the patient is intelligent they can overcome the thirst by rinsing the mouth out with cold or warm water and spitting it out. It relieves them. If it does not, a saline injection of a pint of water into the bowels, carefully put in, will help. But I keep the stomach empty until I have gotten the bowels moved; I do not wait two or three days. After an operation weak enemata to begin with—nutritive enemata—six ounces of food (I am not particular which) in the rectum, and repeat every four or six hours, but no food by the mouth. Treated in that way I have my patient a better and quicker convalescent. The after-feeding is an essential point.

The other point that I wish to bring to your mind is the after-treat-

ment—what we do in the hospital and what is done the first three weeks. By the way, there is another point; there is a disposition to get the patient out of the hospital in a short time. Most of these patients have been long sick, are in a nervous condition, and if you keep them in bed a week or so longer than is apparently necessary, and if they come prepared to stay in bed for some time after the operation, they will be more patient. If you would not tell them that they are going to remain for two or three weeks they would not fret and worry so much when they are kept longer,—I keep them in bed at least three weeks. Dr. Mercer will let them out of the hospital in two or three weeks, but it is not economy for the patient. They are not fit to go out, to go home into society in three weeks or hardly four, but when they do go they are not fit to go to work. I have had the patients sent back to me with the same pain in consequence of going out too early, I am certain. The pain was not the direct result of the trouble, but the indirect result of the trouble. The effect had been going on for ten years; the nervous symptoms and all the constitutional troubles had accumulated, as it were. Some of it is imaginary, but you have to overcome it. The removal of the cause does not always take pain away immediately; if it is due to an acute thing it is removed, but if from a chronic one it is not. So when the patient goes home to go to the doctor the convalescence occurs outside of the hospital. I have letters from the doctor about this patient. When she is asked "What did you do when you were sent home?" "Went to work, washing, scrubbing, lifting," she replies. A patient ought not to lift or stoop over for six months. You should allow the abdominal walls to get strong before you put any special strain on them. It depends on how the abdomen is sewed up whether hernia results. A patient should not be promised a cure in these conditions for six months, and really not for a year; and then they should go back to their doctor for a careful study of their condition, and then use your remedies and care and give them frequent change of location and every cheerful surrounding; but the cure will take time. We fail in results from the expectation of a miracle being performed by the removal of a condition. We are going to do the operation, but they have confidence in their home doctor. When there is any gynæcological case, removal of ovaries and tubes, do not tell them that a great change will be made in their whole constitution. They are going to have this and be that; they are not going to be the good, kind wife and mother. But you do not change the central feelings or normal, material instincts of a woman because you take an ovary out. The system is

built up and they do not change materially when the ovaries are taken out. They greatly dread such a change as that as some awful affliction. It is all nonsense. And you can convince them to expect, if the tubes and ovaries are removed, that they will undergo the gradual changes that all women undergo after the climacteric period.

DISCUSSION.

Dr. W. G. Dietz: The writer of the paper has touched upon the hospital and the patient, but I think you hospital doctors are sometimes amiss in sending and leaving patients go out of the hospital without any and the least instruction for themselves or their physicians. I could cite cases in point, if I were inclined to do so. You surgeons suppose that we country physicians know something about these matters, and often we do not.

Dr. J. E. James: You ought to know about your patient.

Dr. W. C. Dietz: Yes. Here is a case of a patient who several years ago was operated for pelvic abscess. She came home and said I should take charge of it, and that "your doctor knows all about you." Well, I did. I knew a great deal about it that is right. Inside of a week, the case had been returned to me after a few days in the hospital. "Well," I said, "any instructions?" "Doctor says, 'no,' just you go home; he knows all about you." I think that is a mistake. Now, I think it is a very good point when you send them home to remember these things, when we send our patients down to keep them a little longer. When a patient goes down, she says: "I want to go home as soon as I can"—but that is what the patient says, and you have no business to let them come home. These are facts. If some of my confreres who live in the country had the courage to stand up they would repeat the same thing to you and make it much more emphatic than I do.

Dr. W. B. Van Lennep: In the firsst place, I feel compelled to take exception to Dr. James in regard to the results of removing the ovaries. I am satisfied from my own experience—which is an extensive one—and from the consensus of opinion of most operators, that it brings about a rapid and very unpleasant climaxis; and I think the trend today among all of us surgeons who work in the pelvis is to be conservative. Ten or fifteen years ago no one would have thought of removing a pair of pus tubes and leave the ovaries. Today you do leave the ovaries, and that, I am quite sure, is the tendency among the most advanced gynæcologists in both schools. So I would make a plea for the conservative treatment of the female

generative organs. That is the plan I follow in my practice. The absorptive qualities of the pelvis are very small; the stomata between the endothelial cells are very small and they become occluded. For this reason Kelly—and this man who works in the pelvis, principally where the cases are almost invariably sterile, through the fact that the lymphatics are absorbent—is in favor of leaving a quantity of fluid in the abdomen and feeding the patient by "posture," so as to send the fluid up towards the diaphragm or into the intestinal region. In this way they are obliged to throw a large quantity of sterile fluid into the circulation; to a certain extent it takes the place of infusion. Where the lymphatic vessels have not been occluded and we have a septic fluid, such as we meet with in appendicitis, rupture of the intestine, or septic gall-bladder conditions and puerperal conditions, it would not do to raise the patient's hips; by so doing we would throw a large amount of pus into the circulation and produce septicæmia. Fowler has turned the patient in the other direction—sending the fluid down in the non-absorbing pelvis. I follow that rule and am delighted with it. Bearing on the same subject, there is no drainage to equal vaginal drainage. Supra-pubic drainage is thorough, but if we want to drain successfully it must be done through the vagina. Another point, the influence of vomiting.

A good plan to overcome vomiting is the use of Peroxide of hydrogen, but the "postural" treatment, suggested by Fowler, is excellent. The way he was led to see the benefits of this treatment was in a patient who had been vomiting and in regard to whom he found his instructions, as to elevating the bed, had been broken. The woman was having an enema every hour, and in order to give that enema they had to lower the head of the bed, and by the time the elevated posture of the head overcame the vomiting they were ready with another enema. This postural treatment is not always used in driving down the material, but also it is used by gravity in helping the intestinal contents to gravitate toward the pelvis and toward the anus.

Dr. J. W. Hassler: It frequently happens that the anæsthetist is called upon to take care of these cases that are operated. It is the custom at Hahnemann, and also the custom in my work, to give as few stimulants as possible. There was a remark made some years ago in the paper that I wrote for this society that more cases died from over-stimulation following operation than from shock itself. As we know, shock is simply an exhaustion of the nervous system, an exhaustion of the vaso-motor centres. I believe if we could put our cases to bed and let them alone they will re-act and need very

few stimulants, if any. I do not believe, except in an extreme case, and it must be very extreme, that any stimulants are necessary whatever during the operation itself.

As regards infusion, it is a great help, and I believe that infusing helps us more in saving our cases and pulling them through, whether it is into the connective tissues, per rectum or intravenous, than anything else; I believe the cases will survive and return to the normal condition more quickly through saline infusion than through stimulation with strychnia or any other adjuvants. Still, to pull the patient over the breach, to see what the reaction might be, we give a hypodermic of strychnia, and give it low—one-tenth or one-twentieth—and it must be an extreme case, a severe shock. We do give strychnia, but a number of anæsthetists, that is, among our confreres at the hospital, generally give it low. We find better success low than high, one-thirtieth or one-sixtieth; the results are quicker, and it lasts longer.

REPORT OF THE

SECTION OF MATERIA MEDICA.

The Materia Medica Pura—Hahnemann's Contribution to Medical Science, by A. P. Bowie, M. D.
Drugs Used Homœopathically By the Old School, by Edward Cranch, M. D.
Remedies Homœopathic to Non-traumatic Hæmorrhage, by W. G. Dietz, M. D.
Is Our Materia Medica Becoming One of the Lost Arts? by W. J. Martin, M. D.
Phytolacca Decandra, by R. P. Mercer, M. D.
Mercury in Syphilis, by C. S. Middleton, M. D.
The Relation of Pathology to Homœopathic Therapy, by Charles Mohr, M. D.
Digitalis, by C. S. Schwenk, M. D.
Convallaria, by R. T. White, M. D.

THE MATERIA MEDICA PURA—HAHNEMANN'S CONTRIBUTION TO MEDICAL SCIENCE.

BY A. P. BOWIE, M. D., UNIONTOWN.

THAT Hahnemann was learned in all the wisdom of the schools of medicine no one will gainsay who is at all acquainted with his life and writings. Dissatisfaction and repeated failures to cure led him to seek their cause, and after much study and observation and experiment he discovered a natural law of cure by which uncertainty and doubt would give place to certainty and success. After his discovery of the relationship of the disease to its medicinal cure there remained a great work for him to accomplish, viz., furnish a materia medica—a work the like of which had never been published before, and one that was destined to revolutionize the practice of medicine. The works heretofore printed on the subject of materia medica were filled with remedies the properties of which were guessed at by their smell, taste, botanical affinity, chemical composition or experience.

Fabulous virtues were ascribed to many drugs of an inert character, and numbers of compounds were regarded as essential to get

full effects of the drugs. To undertake to construct a materia medica such as was demanded by the laws of similars would have appalled a man afraid of work and lacking in energy, but Hahnemnn was not only a thinker but a worker, and when he set himself a task he was sure to accomplish it. He first published the Organon. And then after many years of weary and painstaking work he gave to the profession his Materia Medica Pura.

Today the list of medicines contained in this work furnishes us with the best medicines we have. And where is the doctor today without his Aconite, Belladonna, Pulsatilla, Nux vomica in his medicine cases. They are well named polychrests. Remedies as efficacious today, when surgery and bacteriology, antitoxin serum therapeutics are fashionable and floods of sample compounds are thrust upon us, and the practice of medicine made easy from pocket-book works and only a line repertories.

What was said by Dr. Charles Julius Hempel in 1854 applies equally as well today as when his pen wrote these lines:

"It is a great shame that the primary sources of our art—the great and immortal works of the founder of homœopathy and more particularly his Materia Medica Pura and his Chronic Diseases, together with the provings belonging thereto—should not be studied more zealously than they are. It is a laborious and fatiguing study. We ought not to forget that these noble works are by far the best part of our art, that our most brilliant cures are achieved with the drugs which were originally proved by Hahnemann and his first disciples."

And yet we are told that homœopathy has not contributed anything to medical science—that we are mere parts, as it were, and that we still look to the old school for all the advances made in medicine.

We have furnished the profession of medicine a practical working materia medica with a law of cure to guide in the selection of the remedy adapted to all climes and in all conditions.

This Materia Medica Pura is Hahnemann's best monument, and the provings contained therein are as reliable as when first published.

It is true we hear a good deal about uncertainty and unreliability of symptoms, and no doubt there are such, but the bulk of the symptoms are reliable and are the best means we have for restoring health. All improvement and advancement in materia medica must be in the same line as marked by Hahnemann and his disciples. The Materia Medica Pura is the model and guide for future work, and it seems to me that the paucity of our literature as regards new provings should be remedied and more work should be done. For surely we

cannot administer a remedy according to our law of cure without a proving.

It is the great need of our school today. Let us be awake to our duty in this regard. Verifications of provings and reprovings should be our life work. Let us keep adding to the work so well begun by Hahnemann.

To use Hahnemann's own words: Thus alone can the power of medicines on the human health be known; thus alone can their true importance, the peculiar action of each drug, be exhibited clearly and manifestly, without any fallacy, any deception independent of all speculation; in their ascertained symptoms all their curative elements lie disclosed; and among them may be found a signalization of all the cases of disease which each fitting (specific) remedy is capable of curing.

It administers *no* medicines to combat the diseases of mankind *before* testing experimentally their pure effects; that is, observing what changes each can produce in the health of a healthy man—that is *pure materia medica.*

What Hahnemann *meant* by *pure* needs no explanation, as a comparison of his materia medica with all others that preceded it shows its superiority, and its absolute necessity if medicines are to be administered according to the method laid down in the Organon of the Healing Art.

I have written this article for a double purpose—to give Hahnemann credit for supplying us with a dependable materia medica and to call the attention of the profession to the practical character of the work, as in these days of "new work" we are apt to neglect or forget the old ones.

Had Hahnemann only discovered the law of cure we would not have fared much better than from previous authors in this line; but he did more, he provided the means of cure.

Let us not forget the pit from whence we were dug, nor the rock from which we were hewn. Hahnemann founded no sect in medicine, but he improved the materia medica section of medicine and made it a science. Neither did he set himself up as a pope, but he gave us a catholic or universal principle to ascertain the virtues of all remedies and how to adapt them to the cure of all diseases. "Imitate me—but imitate exactly," were his words.

Let us continue the work he so well begun, but never let the new remedies take the place of the old, for there are no substitutes in homœopathy; each medicine has its place.

DRUGS USED HOMŒOPATHICALLY BY THE OLD SCHOOL.

EDWARD CRANCH, M. D., ERIE.

THE assertion is often made, and the theory taught in old school colleges and training schools, that homœopathy is "an exclusive dogma," and that all homœopaths who are honest use absolutely no adjuvant treatment, and, further, that those who call themselves homœopaths, and still employ massage, electricity, baths, surgery, emetics, purgatives, stimulants and sedatives, etc., are deserting their standard, and acting the part of hypocrites, who think only of their own gain, and are not in the first place solicitous for the general welfare.

The same instructors declare that "homœopaths would be greatly handicapped if they had to be honest and do without these adjuvants."

To this we rejoin, that we are first of all physicians, and aim to acquire information on every branch of our subject, and that in declaring ourselves homœopaths we assert our adherence to the "only law" (accent on the "law") in therapeutics. That we use apparently diverse means to secure the operation of that law is no argument against its universality and real exclusiveness, for "action and reaction are always equal and opposite," and the real cure is always performed by the vital forces reacting against disease, but needing to be roused to that reaction by whatever stimulant, whether drug, massage, knife or caustic, is selected (properly) to assist nature by securing the needed changes that lead to health.

The special field of homœopathy is the selection of drugs which, having declared, in their provings, a special affinity for a certain organ or function, or group of such, are chosen to rouse reaction in those same organs and functions when diseased. In this mode of practice we have found it expedient to reduce our doses to avoid the evils of too great reaction, just as the old school man reduces his doses of electric current, of his salt baths, of his daily or weekly massage, and the sweep of his knife or caustic, if he fears too violent an effect.

Now if the homœopaths can be considered handicapped if they should abandon every means of securing healthy reaction except the

use of small and tasteless doses of medicine, how would the physicians of the old school be handicapped if they had to abandon all of drugs and adjuvants that depended for success on their strictly homœopathic action?

Let us glance at a list of some of their favorite prescriptions, promising that in these very directions, where they often begin by getting the most flattering signs of improvement, they most often end by permanent failure, the disease at first being benefited, but becoming finally fastened hopelessly upon the patient by a want of knowledge of the law of similars, which is that every drug or agent capable of benefit is capable of the opposite harm, in like degree; hence a knowledge of how to use a drug must include a knowledge of what dose is best to use, and a further, most important knowledge of all, a knowledge of when to arrest its action.

Although physicians of the old school prefer to acknowledge no *law* of cure, they are dependent on the operation of that law when they treat anæmia with Iron; malaria with Quinine; Gout or rheumatism with Colchicum, Salicylic acid or Lithia; syphilis with Mercury; itch with Sulphur; boils and abscesses with Calcium sulphide; catarrhal discharges with Hydrastis; pulmonic affections with Ipecac., Tartar emetic, Sal-ammoniac, Cochineal, Seneca, Aconite, Chlorate of Potash, etc.; angina pectoris with Carbonate of ammonia and Nitro-glycerine; amenorrhœa with Conium; malaria, anæmia and œdema with Arsenic; hysteria with Asafœtida, Valerian and Musk; sore mouth with Borax; sore eyes and throat with Nitrate of silver; delirium tremens with Hyoscyamus and Cannabis Indica; debility with Phosphorus and its compounds; liver complaints with Nitric acid; paralysis and dyspepsia and alcoholism with Strychnia or Nux vomica; and so on, in a list too long to enumerate. We do not suggest that they abandon the use of these agents, but only that they learn how to use them properly and so do less harm with them, and find out by analogy how to use many agents they are obstinately ignorant of, such as Croton oil, Veratrum, etc., in diarrhœa; Lead, Opium, etc., in constipation.

"In a science having for its object the saving of human lives ignorance becomes a crime."

DISCUSSION.

Dr. C. W. Roberts: We are all interested in each of these papers, and everyone says ditto, ditto. There are but a few things of which a man can be justly proud, and I believe that every man who is a

homœopathic physician can be justly proud that he is a physician and a homœopath when we consider the conflict against prejudice through which it is passed—but truth is mighty and truth will prevail, although learned doctors oppose it. Electricity, baths, heat, cold, mineral waters were all scoffed at in their infancy, ridiculed in their youth, but universally accepted in their manhood. It is so with homœopathy, but whether mighty men and forces and reinforcement continually arriving by organization and union of thought and purpose, the youthful homœopathist has grown to be a stalwart in the land. The days of poly-pharmacy were numbered when Samuel Hahnemann proved the individual power of drugs, taken from that great conglomerate, the old materia medica, and stamped on it "drug ability," of the medicinal materials of the world. The homœopathic law introduced and promulgated by Hahnemann stands just as good today as it did in Hahnemann's day, and is a law that can be followed out. While we have a great many adjuvants that are good and relieve suffering, they relieve and only relieve; but when you want a cure you will have to go back to Hahnemann's law of cure. Homœopathy, through all its battles for life, has not asked any legislators to help them enforce it upon the people. In fact, anything religious or political or medical that needs the fostering care of legislative power by enactments shows inherent weakness and will be condemned by the public sooner or later.

REMEDIES HOMŒOPATHIC TO NON-TRAUMATIC HÆMORRHAGE.

BY W. G. DIETZ, M. D., HAZLETON.

In presenting this short paper to your consideration, it is not my purpose to give the indications for each and every remedy that may be required in a given case, but, rather, to confine myself to such which by this pathogenesis and by clinical experience have proved themselves worthy of our consideration; nor shall I, in doing so, follow any nosological arrangement of diseased condition as alphabetical series of remedies.

The term hæmorrhage is here used in its widest sense—an abnormal flow of blood—irrespective of quantity or cause. Epistaxis may be a trivial, scarcely to be mentioned, abnormality; again, it may

prove the bete noir of our best directed efforts. The scope of this paper excludes the consideration of such other means as do not come within its scope. Here, as elsewhere, the tolle causam must never be lost sight of, the conditions presenting may be such as to seriously threaten the life of the patient, and the physician must ever be in full command of all resources that will help and assist him to bring about a favorable termination. With these preliminary remarks I beg to bring before you some of the remedies to be thought of in the management of a hæmorrhage.

An active hæmorrhage of bright red blood, coming in gushes and accompanied by pale face, cold sweat, *nausea,* with gagging and tendency to faint, calls for *Ipecac.* Should this fail to bring prompt relief, and, added to the foregoing symptoms, we have frequent yawning, ringing in the ears, attacks of syncope with flickering, irregular pulse, *Cinchona officinalis* is called for. If actual collapse sets in whole body becoming cold, even the breath, patient begs in a whisper *to be fanned* and to be *fanned hard,* pulse scarcely perceptible, *Carbo vegetabilis* is our last trump. These three remedies are indicated especially in cases which rapidly threaten the life of the patient. A hæmorrhage of bright red blood, accompanied by great mental excitement and restlessness, a flushed face and the positive assurance of the patient that this will be the last, requires *Aconite.* If such a hæmorrhage, accompanied by flushed face, with visible throbbing of the carotids, the patient rather calm, even desiring death, the blood feeling very hot, with throbbing or shooting pains in the part involved, do not forget *Belladonna.* Another remedy that should not be forgotten in hæmorrhage with flushed face and violent thirst for ice cold water is *Phosphorus.* This remedy, indeed, has proved itself the most reliable curative agent in my hands in all hæmorrhages that go on for days and weeks, not a great flow; in fact, in just such cases where the patient is least cognizant of his danger, a flow that has for its immediate cause that short but most important symptom small wounds bleed much, compare here with *Lachesis.* Blood coagulates rapidly in *Phosphorus,* slowly, or not at all, in *Lachesis.* The distinction has not always proved true at the bedside. I have seen *Phosphorus* arrest the persistent oozing of blood from nose and throat in diphtheria and save the patient after *Lachesis,* apparently indicated, had failed. About eight years ago a denizen of the City of Brotherly Love, but temporarily residing at Hazleton, had suffered from persistent epistaxis for two weeks, and been under old school

treatment. *Phosphorus* arrested the flow, with no return of the same while he remained within reach of my observation.

Mrs. E., aet. thirty-seven; lean and slender; narrow chested; a sister died from pulmonary phthisis; has expectorated blood for two years, with but short, temporary periods of freedom from it; blood bright red, in small quantities, free or intermixed with mucus, shortness of breath, can't lie on left side and accompanied by a dry, hacking cough. *Phosphorus* cured her. Four years have passed over without a return of the hæmoptysis. In the bleedings from neoplasms always think of *Phosphorus*. *Ferrum* should be remembered when the blood is bright red, partly clotted, partly liquid, with a pale face that flushes up with every passing excitement, be it ever so trivial, *great weakness,* paleness of mucous membranes. Perhaps the most frequently used remedy, in a routine way, and next to Ergot, is *Hamamelis,* of Pond's Extract fame, and certainly worthy the laurels it has won, yet not a specific. Its indications are, a flow of *venous blood,* generally accompanied by soreness of the part affected, and a calmness of mind strangely at variance to the otherwise serious loss of blood. As is well known, the cause of the *Hamamelis* hæmorrhage lies in a diseased condition of the veins, generally varicosis. About two or three years ago I was called to see a well built, but pallid looking, Irishman. He was very weak; dizzy on assuming an upright position; no other complaints except a slight, hacking cough. Diagnosis of previous attendant consumption. Had had frequent hæmorrhages from rectum, due to hæmorrhoids. *Hamamelis* arrested the hæmorrhages, and *Cinchona* did the rest; he is well. Another remedy used and abused by representatives of all schools of medicine is *Secale cornutum,* the Ergot of the allopathic school. We all know its primary effect, the constrictions of the unstriped muscular fibre, and its long continued use resulting in devitalization of blood and nerve-centers. Homœopathically, it is indicated in hæmorrhages occurring in withered, dried-up constitutions, great weakness irrespective of blood losses; the flow itself is passive, venous, dark, liquid, and generally unaccompanied by pain; a feeling of coldness with aversion to heat and covering, when present, will prove a reliable indication for the administration of this remedy. It is most frequently called for in uterine hæmorrhage, owing to its affinity for the unstriped muscular fibre of the uterus. Its nearest analogue here is *Ustilago.* It will often prove curative in frequently recurring and long-lasting metrorrhagias, especially when associated with pain in left ovarian region. The flow is apt to

be rather free, bright red and always contains *clots.* A lady about thirty-eight years of age, full habit and with the exception of easily deranged digestion, otherwise in good health, has been for some years past subject to at first infrequent, but later more closely recurring, attacks of profuse and prolonged menorrhagias. *Trillium* at first controlled, when it failed *Hydrastin muriaticum* helped for a long time, but finally reached the end of its usefulness. Physical examination revealed a flabby and somewhat enlarged uterus. *Ustilago* promptly relieved and there has been no return now for a year past. I mentioned *Hydrastin muriaticum,* which has served me well in several cases of prolonged metrorrhagias. It acts antipathically, and I have no special indication to offer. Another remedy to be remembered in long continued losses of blood is *Millefolium,* especially uterine, flow bright red, fluid, if brought on by over-exertion, falls; here compare *Arnica.*

In the selection of the remedy, the general constitutional symptoms of the patient must always be considered, especially in long-continued or recurrent hæmorrhages, as *Carcarea carbonica, Arsenic, Nitric acid, Leptandra, Pulsatilla, Sulphur,* etc., can rarely be thought of otherwise.

In metrorrhagia, in its widest sense, besides those mentioned before, the following remedies deserve mention:

Coccus cacti: Passes clots of very large size, < when quiet, > when moving about.

Sabina: Profuse hæmorrhage of bright red blood, < least motion; this may be > by walking. Pain from sacrum to pubis.

Erigeron: When accompanied by vesical and rectal irritations.

In the renal hæmorrhage, besides *Terebinthina* and *Cantharis,* etc., *Calcarea phosphorica.* This remedy was brought to my notice many years ago by an article in one of the ancestors of the Hahnemannian Monthly, the author, the name of whom I do not now remember, relating several cases of renal hæmorrhage successfully treated by this remedy. I have confirmed this observation some years ago in an old man who suffered from hæmorrhage at intervals of several weeks to months. No pain or other disturbances; this remedy cured him.

Antipyrine in material doses has been claimed as a sure hit in epistaxis, *Phosphorus* and *Carbo vegetabilis,* however, are better. Intestinal hæmorrhage, such as occurs in zymotic diseases, generally require *Lachesis, Nitric acid, Kali phosphoricum.* In hæmorrhage with

marked morning aggravation, don't forget *Acalypha indica,* especially in hæmoptysis.

DISCUSSION.

Dr. J. W. Thatcher: I would like to mention Trillium. I have great success with in it metrorrhagia and during the climacteric; blood very profuse and very bright red.

Dr. G. W. Roberts: Acalypha Indica has served me, and I have used it in many cases. I believe it is one of our great remedies for hæmorrhage. There is where our homœopathy comes in again in hæmorrhages. When you get the homœopathic remedies, such as Pendulum, Belladonna, Aconite, Ferrum or Phosphorus, any homœopathic remedies well indicated, the hæmorrhage stops if it is at all curable. Of course, we find conditions sometimes for which we can't seem to get hold of the right homœopathic remedy. It is only because we do not know our homœopathic remedies thoroughly. Then we are justified in stopping the hæmorrhage for the time being. While we have gained a great many victories, we can be independent in some respects; we cannot be so altogether. We must add, it is sometimes necessary to apply heroic measures. We cannot let newly found facts pass by. We have the antitoxin—we have the medicine that does the work. We can usually though rely on our homœopathic remedies, and it is seldom we need to have recourse to anything else, if we are familiar with our materia medica.

Dr. J. E. James: In hæmorrhages from malignant growths, Hydrastine hydrochlorate is good.

Dr. M. J. Holben: In regard to epistaxis, when I started twenty-five years ago I made a wonderful cure with a young man. He had nose bleed for two or three years. He said he tried eight physicians and was bleeding every two weeks, which left him in a very weak condition. I gave him a few doses of Camphor (30th) and he never bled afterward. And also an old man troubled with nose bleed; I gave him the same remedy and it cured him.

Dr. F. D. Brewster: There is one remedy which was suggested to me by the gentleman who spoke last. I recall curing several cases of habitual epistaxis, hæmorrhage in the morning, worse in the morning, with Bryonia. I do not think that remedy has been mentioned before, but I find Bryonia an excellent remedy in habitual epistaxis.

Dr. J. W. Thatcher: What is your indication?

Dr. F. D. Brewster: Aggravated by motion, and generally in the morning.

Dr. J. W. Thatcher: Any peculiarity of the blood?

Dr. F. D. Brewster: Blood generally bright red—flushed face.

Dr. J. W. Thatcher: I have obtained the best results from Ferrum metallicum.

Dr. A. P. Bowie: Ammonium carbonicum is useful when the patient's nose bleeds when he washes his face or wipes it on the towel, and this will occur every morning until it is cured. I have never used it in any other potency than the thirtieth.

Dr. E. S. Snyder: I was called in to see a girl fourteen years of age two years ago suffering with epistaxis regularly every month. However, her monthly period had not yet been established. She had a bright red arterial hæmorrhage and it was very free, and I noticed the girl picking her nose and working around it. I asked her: "What is the matter?" "Oh, I have the sharpest, stinging pains in my nose." She had been under the old school treatment at that time. I gave her Nitric acid, and the father told me a year after that she never had another hæmorrhage. I prescribed for that hæmorrhage on the one symptom of sharp, stinging pain with the arterial hæmorrhage. I did not see many symptoms by which to choose. I then had another very good case, thinking of Calcarea phosphorica—a case of recurrent convulsions from the time the monthly period would come on; a young woman twenty-two years of age; she was a Calcarea patient. I would notice that she was not breathing very freely and was spitting dark blood, had a slight hæmorrhage, and then had thirty-two convulsions—every morning until 10 o'clock at night. They had an old school physician, but he refused to come again. He said he had done all he could, could not relieve her, and that she would die. They came to my office. I called on the patient and gave her Calcarea phosphorica. She got along very well and she did not have any recurrence for a whole year. When I was called again she had eight convulsions and has not had any from that time to this—that is three years ago. I thought these cases would be worth while hearing.

Dr. E. M. Gramm: It is well known that the aromatic Sulphuric acid is used by the old school to cure hæmorrhages very efficaciously and rapidly. The Sulphuric acid has not been mentioned, and it recalls a case to my mind that I had some years ago—a child five years old—who had double pneumonia. The case had an alarming hæmorrhage, exceedingly restless and exceedingly feeble, so much

so that the child would sink down in the bed and was utterly unable to hold herself upon the pillow. I gave that child Sulphuric acid in the sixth centesimal potency and controlled the condition very nicely. It was not only an amelioration of the hæmorrhage that occurred, because the child was going down and down and down, until the Sulphuric acid was given, but shortly after I gave the Sulphuric acid it was very perceptible that a change for the better was gradually taking place, and the child recovered, although it was an exceedingly serious double pneumonia which was the exciting cause of the hæmorrhage.

Dr. Coolidge: I had one experience with supra-renal capsule locally; it is claimed that it will produce the same effects as if given internally.

Dr. Charles Mohr: I was very glad to hear Bryonia mentioned in respect to nose bleed, and to bright arterial nose bleed, with markedly pale face, aggravated from motion. I have used Bryonia in nose bleed, particularly in plethoric washer-women and in negroes, who, of course, get very much overheated from the wash-tub and subject themselves to steam heat, and at the ironing board, etc., and then when they get through with their work they will use the cold water faucet and wash the face, which very frequently gives rise to epistaxis. If you get such a case as that Bryonia will stop it and cure it. Another peculiar experience I have had in some venous subjects, women particularly with climacteric disturbance, when there may be an occasional epistaxis in place of menstruation which does not ensue, in passing through the change of life, with this peculiarity added to it, that the nose will bleed in the morning in the act of cleaning the teeth. What the act of cleaning the teeth in the morning has to do with the excitation of the nose bleed I can't explain, but when the nose bleeds when cleaning the teeth Sepia will cure.

I do not think that Cina has been mentioned. You usually think of worms in connection with the remedy. I recall a case coming to me last year of a woman who was quite anæmic from too much menstruation. She had menorrhagia. This menorrhagia was always associated with marked nervous symptoms, and these nervous symptoms showed themselves by a constant picking of the nose until the nose would bleed. Cina cured that case. Sometimes we are confronted with cases that require mechanical treatment before we can relieve certain conditions present. Now, I recall a case of great interest to me, because I was able by the treatment of that case to show a well-known old school doctor of New York the efficacy of homœo-

pathic treatment. He was a man who always derided it, and his own niece was a patient of mine after having given birth to a child, and then, after menstruating regularly for sometime, never became pregnant again, but was more and more affected by menorrhagia, and finally menstruation was so excessive that her uncle was consulted and he sent the patient to Dr. Skene, of gynæcological fame. He examined the woman and he found a fibroid in the uterus about as large as my fist, with retro-flexion, and with adhesions from some antecedent pelvic inflammation, and he said: "The only thing to do here is to operate; but I do not feel justified in operating this case now; let us wait and see what the result of other treatment is." So, at each menstrual period, after bleeding excessively, she would be built up by tonics. Of course, she was put to bed and rest obtained and was given all the change of fresh air that could be desired. She continued to get worse and worse and worse, and then the courses came as often as every fourteen, sixteen or at most seventeen days, the menstruation lasting from a week to ten days; then simply two, three, four days comparatively free, and then the thing would come over again. Now, a brother-in-law of hers who had always been a staunch homœopath, and used to be a patient of Dr. Fincke, of Brooklyn, had many a fight with this old school doctor about the relative merits of homœopathy and allopathy, and the old school doctor always condemned homœopathy; but he induced his sister-in-law to come to Philadelphia and try homœopathy, and he said that he did not believe there were very many good homœopaths in Brooklyn or New York City. I do not know what he means. (Laughter.) This woman really did consult me, and I found it necessary to relieve her pains and reduce her temperature, which would rise to 99 and 101 in the evening and in the morning be normal; tenderness in the right side of the abdomen with some dense inflammatory product there which, at that time, I did not make out; the characteristic pains led me to give her Belladonna. I started her on that within two days, the Belladonna conjoined with rest in bed and milk diet; I would not allow anything else. She was relieved entirely of her pains and the fever was reduced so that in the afternoon it was normal and continued so. I made a very close study of her case and arrived at the conclusion, and referred to that this morning, where you have an indication for Belladonna for acute symptoms you have the Calcarea carbonica, the remedy that will cure a case if it is curable. I put her on Calcarea ostrearum. I gave her the sixth decimal trituration night and morning and then sent her to Brooklyn, advising her to use all hygienic

measures. I made no promises. I treated her by mail, got several letters week after week. After Calcarea was given the next menstrual period came at eighteen days, and it only lasted six days, and she did not feel uncomfortable afterward. The next period came in twenty-four days and it was a perfectly normal menstruation, without any symptoms of ill health. The next month menstrual period came at twenty-nine days, perfectly normal, and she has been menstruating normally ever since. Now, the fibroid uterus is still there, the adhesions are still there, but the Calcarea ostrearum controlled that case and now she is in the hospital in Philadelphia, sent by her own allopathic doctor, to be treated for hepatic trouble, gall-stone disease I believe; I have not examined her yet.

Dr. J. W. Coolidge: In young girls with hæmorrhage from vicarious menstruation Bryonia has cured all my cases.

IS OUR MATERIA MEDICA BECOMING ONE OF THE "LOST ARTS?"

W. J. MARTIN, M. D., PITTSBURG.

In this paper I will narrate some of the circumstances and incidents that have led me to present the query which is the paper's title, and leave you draw your own conclusions. At our hospital we get a fresh set of internes every year. They are generally bright young fellows, fresh from the "Halls of Galen," earnest and enthusiastic in the determination to go out into the world well equipped with the knowledge and some of the practical experience that go to make a successful physician. But there is one thing that I have noticed about these young graduates, and I notice it more and more each succeeding year, and that is, that as a rule they know less about homœopathic materia medica and therapeutics than they do about anything else pertaining to the general practice of medicine. A recent incident in illustration: One day last winter I visited the hospital, having been absent for several days. The junior resident accompanied me on my rounds. In a private room was a man with typhoid fever. He had been sick about two weeks. There had been nothing peculiar about the case, except that it seemed like one that was going to drag along a good while. He was taking Rhus, and for a week or more the evening temperature stood between 103° and 104°.

He was a red-faced man and was not very refined in his ways. The resident handed me the records, and we looked over the history of the case as recorded by the nurse. The last two days the nurse had made record of the fact that this patient was annoyed by burning of the soles of the feet; she had much trouble in keeping them covered, as he persisted in putting them out from under the covers, and she feared he would take cold; and he declared he could not tolerate the burning when under the covers. She would cover the feet, expostulate, possibly scold, and leave him to attend to other patients, and on returning he would have his feet uncovered. She very properly made prominent mention of this feature each day, never dreaming what a good service she was thereby doing.

"Now," to the junior resident I said, "burning of the soles of the feet, wants them uncovered," is a very prominent symptom of a remedy, will you name the remedy?" To my astonishment he said he did not know it, had never heard of it. I told him "it was time he did know, that when I was at college we all knew that symptom long enough before we graduated, many of us before we went to college. It is Sulphur. Write a prescription for one dose of Sulphur 200 every morning for three mornings and then no more medicine until it was ordered." When the patient had taken the third dose he had no need for any medicine. Everything was normal, and in a few weeks he went out of the hospital well and quite strong. The junior resident in extenuation of his ignorance claimed that Prof. M. had not lectured on Sulphur. I thought that in all probability Prof. M. had given so much of Sulphur by way of comparisons in lectures on other drugs that it was not thought necessary to take time for a special lecture on that remedy.

Another incident: When I took charge last winter there had been several days elapsed since the last visit of my predecessor. In this interval several cases of acute muscular rheumatism were taken in, and were prescribed for by the resident on the medical side. I noticed that he was giving them all the same thing,—and no two of the cases were alike by any means,—he was giving them all Colchicine in some kind of dilution. I asked him what symptoms called for the administration of this remedy, as I was not familiar with it. He told me it was indicated in all cases of acute rheumatism where there was high fever and the patient suffered very much pain. "Where did you learn that?" "That is taught at college." "Well, that is not the way patients are treated here while I am on duty." I then explained to him the way to prescribe for patients as I had learn-

ed it at college under the tuition of a certain Prof. Korndoerfer some twenty-three years ago, and which has since always served me well. The day before this the same interne had an interview with me over the telephone. He told me a case had just been brought in which was evidently a bad case of cerebral apoplexy,—unconscious, stertorous breathing, contracted pupils, etc. "Would he pack his head in ice?" "No, administer the indicated remedy and leave his head alone," was my answer. I thought that it would take this young man some time to unlearn some of the things he had learned at college.

Nash's "Leaders in Typhoid" came out about this time. I presented the young doctor with a copy, and when I went off duty he was doing some very good prescribing.

I was at a meeting of a medical club not long since. I very rarely go to our medical society meetings any more, because there is little or no homœopathy in them—but this club does serve some elegant luncheons which I enjoy very much. On this occasion the treatment of post-partum hæmorrhage was being discussed. One of the young members, a graduate of one of our best,—so considered,—homœopathic colleges, remarked that he would be afraid to trust to homœopathic remedies in such a serious condition as post-partum hæmorrhage. What do you think of this? A declaration such as this to be made in a homœopathic medical club, and it passed unchallenged. I was an invited guest. I did not say anything, but I thought it would be interesting to know in what kind of conditions this young man did trust to homœopathic remedies.

At another meeting of the same club a young member,—a particularly bright young man—so considered—occupied a large share of the evening in describing in minutest detail the process of treating gonorrhœa by copious injection into the bladder of a, I think, five per cent. solution of Permanganate of potash, the bladder being filled with the solution; the patient is then to evacuate it. He told of his success in a number of cases recently so treated. Another member said he was having success with the Bromide of camphor in priapism and chordee accompanying gonorrhœa. "The old school," he said, "are using it very extensively." I was a guest. I said nothing, but I thought were it possible for Hahnemann himself or some of the "Old Guard" to come in spirit to this meeting they would not for one moment suspect that it was a meeting of a homœopathic medical club. Commenting upon the recent meeting of the American Institute of Homœopathy, the Philadelphia Medical Journal (old school) says, July 7th, 1900, in part, as follows: "In the

city of Washington on June 21st the American Institute of Homœopathy unveiled with fitting ceremonies a monument of Samuel Hahnemann. President McKinley occupied the most prominent seat upon the platform, where sat also H. B. F. McFarland, Commissioner of the District of Columbia; General John M. Wilson, and Mr. Cortelyou, Secretary to the President. Attorney General Griggs delivered a short and spirited oration. The monument, very beautiful from an artistic standpoint, occupies one of the choicest positions in the city, facing the statues of Gen. Winfield Scott and Daniel Webster.

"Specialism, into which field the homœopaths have freely entered, occupied the greater part of the purely medical side of the week's transactions. The papers read did not differ materially in their points of view from papers upon similar subjects read before other medical bodies. Owing to the time occupied in thanking the Monument Committee and the President of the United States, etc., exactly but two hours were spent in reading and discussing papers at the meeting of the section of materia medica. The treatment of diseases allopathically was stated by Dr. E. C. Price, of Baltimore, to be right and proper under certain circumstances, i. e., upon the failure of homœopathic remedies, for Hahnemann says, 'the first duty of a physician is to relieve the sick.' Doubts and disagreements with the principles of Hahnemann are, to use the words of a disciple present, 'creeping into the journals, hospitals and colleges of the homœopaths.' Indeed the tendency of the whole meeting went to show that the term homœopath is but a trade designation and does not include adherence to the principle implied, and yet the homœopaths have raised in the capital of the United States a monument resembling an altar, upon the base of which are inscribed the words 'Similia Similibus Curantur.'"

I was one of the many who did not attend the meeting of the section on materia medica, consequently do not know personally if Dr. Price, of Baltimore, said Hahnemann says, "the first duty of a physician is to relieve the sick." I do know though that Hahnemann never said any such thing. What Hahnemann did say was, "The Physician's highest and only calling is to restore health to the sick, which is called healing." Relieving the sick is not restoring health to the sick, not always, I am sure. If, as reported, Dr. Price said it was right and proper to use allopathic remedies when homœopathic remedies failed he was very unfortunate in making use of such an expression,—an expression that never should be made use of,—for

homœopathic remedies do not fail—the failures are due to the fact that remedies used had not been the homœopathic ones. The rest of the report that I have quoted is substantially true and correct.

It is true and correct that "the papers read in the various sections were in the line of specialists, and did not differ materially from papers on similar subjects read before other medical bodies," and if it is not true, it is pretty nearly true, that the tendency of the whole meeting went to show "that the term homœopath is but a trade designation and does not include adherence to the principle implied."

A great deal was said at this meeting, a great deal has been said at other meetings, a great deal has been published in some medical journals of our school concerning the definition of the term "homœopathic physician."

On the title page of the last volume of the Transactions of the American Institute of Homœopathy appears, conspicuously, under the headings Authorized Definition, and Definition of a Homœopathic Physician, a lot of stuff about "great field of medical learning," "by tradition," "by inheritance," etc., it makes one tired to read it.

One of the greatest men this country ever produced was Abraham Lincoln, the martyred President. This I believe is conceded by all unprejudiced students of American history. He possessed the faculty to a degree that no man ever before did, and probably no man ever again will, of expressing great ideas in the simple language of the plain people. It was he who said, "You can fool all the people sometimes; you can fool some people all the time; but you cannot fool all the people all the time." Those persons who have been cudgeling their brains, and juggling with words, in the vain work of framing specious definitions of a homœopathic physician may succeed thereby in fooling some people all the time, and of fooling all the people for some time, but it is as sure as fate they will fail to fool all the people all the time. This definition-making episode has revealed a remarkable mental condition on the part of those who are working up these various specious definitions. It has revealed the sublimely ridiculous spectacle of a set of men—educated men, too—trying to fool themselves, trying to make themselves believe, by some play upon words, that a man who does not practice homœopathy is, or may be, a homœopathic physician. They all know as well as we know, and as every one knows, that instead of it requiring thirty-five words to define homœopathic physician, which is the number of words in the authorized definition—some of the unauthorized definitions have a great many more—eight words only are required, viz.: A

homœopathic physician is one who practices homœopathy. This is what a homœopathic physician is, this, and nothing more, but all of this.

Fondly do we hope, sincerely do we pray, that future editions of the Transactions of the American Institute of Homœopathy will not continue to make us the laughing stock of the whole country by the continued publication, conspicuously, of those "Authorized Definitions."

DISCUSSION.

Dr. Charles Mohr: In the first place, I want to say that the medical education of the present day is not what it was when Dr. Martin and I were students, and so far as that is concerned there is not very much more to learn than there was twenty-five years ago; in the second place, when Dr. Martin and I were students he devoted very much more time to the study of the homœopathic materia medica than the students of the present day are able to devote to that study, because there are so many other things that have come in and appear to be neccessary to dwell upon that the lectures upon the homœopathic materia medica are curtailed in order to give him time to develop all these other things that a well-educated physician should know. Now, it is not the college alone that is at fault; it is not the individual teachers who are at fault; it is not the students that are at fault, and I am going to throw the blame where it belongs, and that is the homœopathic profession. Now, I know a great deal about it; I know how the students come to our institution. I know how they have been talked to by their preceptors and by the physicians with whom they are brought into contact. They are told "When you go to college get all the pathology you possibly can; you can get materia medica afterwards." They say, "Get all the surgery you can; do not neglect these surgical clinics; see all the surgery possible. You can get the materia medica later." That is bad advice to give these students. I say it here emphatically, because I believe the homœopathic materia medica and the use of that materia medica on the principle of similars given us by Hahnemann is the capstone of medicine and includes everything. The physician has need for it, the pathologist has need for it and the surgeon has need for it; and when the pathologist neglects it and the surgeon neglects it he neglects the very thing which would be of pertinent interest to him long after his mechanical skill has been aided by those features. I speak feelingly on the subject. If these students had not been wrongly impressed by

the physicians who gave them the advice, had deemed it just as important to attend my lectures as to have attended a lecture on pathology or a surgical clinic, he would have known all about Sulphur, because I always teach Sulphur, and there are gentlemen right in this room who heard me three, five, six, ten years ago who know that is a fact. Now, there is another thing I want to say in regard to teaching homœopathy, and that is in all my practice—private practice and hospital practice—I have never administered a single dose of Colchicine in a case of rheumatism. I have never in the treatment of typhoid fever advised anything in the way of medicinal treatment except the indicated medicine according to the principle of the similars. I have never used a hypnotic as such; I have never used a narcotic as such; I have never used an astringent, as such, in a case of hæmorrhage; I have never used a heart tonic, such as Digitalis, etc., and I can say this, that in the treatment of our hospital ward typhoid cases —241—covering a period of six years, all those patients of typhoid fever did not consume a pint of whiskey or brandy, as a general stimulant. That is what these students are taught—they can do without it. If they understand what is to be given in the way of a homœopathic remedy and give it in small doses, and look for a cure, which is absolutely sure to come in all curable cases, it will be quicker and more permanent than any case in any other method of practice.

I do not know whether it is wise to say all these things, but I do want to support my colleagues. I believe in my Alma Mater and so does Dr. Martin in his heart, but he is talking against pernicious teaching. So am I, and always will. I just want to say for the moral effect it will have upon the young men who are going to study medicine, that when you come in contact just advise them to stick to the principles of homœopathy as they are taught in that institution and not allow anything to take its place.

Now, taking typhoid fever into consideration, I was very much interested in the outcome of an investigation which I did not know how it was going to come out; I did not know any investigation was being made; but some of our doctors left the hospital service last May—who had been there for a period of eighteen months—and had watched the treatment of all cases in the medical wards and knew perfectly well that I was treating strictly according to the principles of homœopathy. Here was doctor so and so treating a case the same way; here was another doctor treating a case the same way, but here comes the fourth doctor who used stimulants, such as whiskey and brandy; here was another doctor who used turpentine stupes, here

was another doctor who even does more than that. Now, I happen to have a little slip of paper which was handed to me by one of the internes after the investigation was made, and it is a telling story. For a period of six years (this covers the period from April 1st, 1894, to 1900) there were two, four, six, eight, ten, twelve physicians on duty as visiting physicians. They treated cases of the same kind under precisely the same environment, getting the same general management, confined within the same four walls, subjected to the same kind of draughts and heat, the same kind of bad air and good ventilation, as the case may be. Now, then, the environment was precisely the same. Then, when my first three months' term of duty was over I turned my cases over to my successor, and when his term expired he turned his cases over to the next one, and during the six years we treated the same kind of cases—pneumonias, rheumatism, typhoids, gastric ulcers, malignant diseases, consumption of the lungs, etc. Well, now, the six doctors—I am not going to mention them, I guess you know them—perhaps they would defend themselves as I am defending myself, the six doctors who invariably made use of stimulants of any and every kind, had a mortality rate of twelve and nine-tenths per cent. The other class of physicians who very rarely made use of these things—very rarely—had a mortality of only six and four-tenths per cent., just one-half less. Then I thought to myself when this comparison was given to me, we will see how this thing turns out. If we take into consideration the doctors who treated the cases during the same length of time—for when this comparison was made some doctors had only been in the hospital service a year, some two years, some three, four, five and six years. Then the men who used these other agents had a mortality of nine and three-tenths per cent. and we good homœopathists—and I am glad to be able to call myself a good homœopathist—had a mortality rate of six and nine-tenths, the mortality being just one-third less than those cases treated on the other side. Now, I think that is a telling result. That means something, and it means just what Dr. Martin indicated in his paper, that we must stick to our principles.

Dr. Price was not properly quoted. Dr. Price simply said that sometimes the antipathic use of Digitalis in certain heart cases was the best use to which Digitalis could be put. He did not say that allopathy was better than homœopathy; he did not even intimate that.

I would say one other thing as to definition. I think the doctor says that the homœopathic physician is the doctor who practices

homœopathy, or words to that effect. So he is. But I tell you where there is a loop-hole—we are compelled to treat cases to which homœopathy does not apply at all. For instance, if I have a case requiring mechanical treatment I am not a homœopathist for the time being. If I have a case of poisoning I must use antidotal treatment; I am a toxicologist. Therefore, I can do very much more than the homœopath as described in the definition. What we want to have defined properly is that in the cases that indicate a similar medicine only that doctor can be called a homœopathic physician who applies the principle of similars to those cases. I am sorry I had to take up so much time of the Society, Mr. President, but this thing stirred me up so I could not sit still.

Dr. C. C. Rinehart: I am glad to know that the doctor was stirred up. I believe in homœopathic treatment and homœopathic materia medica. I was glad that Dr. Martin spoke of these things, because I have had abundant reason to find fault with this very thing, coming as I did just before Dr. Martin in the medical service at the same hospital. I can for one express myself in this way: I believe that the homœopathic remedy never fails. Where you get the homœopathic remedy, where you get the remedy that is indicated in a case, it cannot fail. We fail in our prescribing simply because we do not know the materia medica well enough and do not prescribe as we should prescribe.

Dr. J. W. Thatcher: I feel that I must unburden my mind on this. If our young men were only taught absolutely pure homœopathy! Dr. Mohr in his chair, followed by the man who teaches the practice of medicine in his chair—if they worked in unison we would have better homœopathic doctors today. But no—they are taught the use of the hypodermic syringe, taught to give morphine, and this, that and the other thing that is not homœopathic. What is the result? Every day almost—and I have a host of allopathic doctors who visit me and they are good men, they are sincere men, they are loyal to their profession, to their fellow-men, and there is a unity in the allopathic ranks—they stand shoulder to shoulder and help each other. Where is there unity in our ranks? It does not exist. There are certain cliques. There are men who believe as I do in the homœopathic remedy absolutely, and I have been at it nearly thirty years. I have had a compliment paid to me by one of the greatest and best undertakers in my town: "I have had thirty-two cases to bury, but you have fewer deaths than any man I know." And why? Anybody else can have it—it isn't all luck. I am careful; I keep a

record of every single, solitary case that comes into my office. I have printed blanks with the name, occupation, residence, and the date. I keep a regular symptomatic history of each case and the remedy given, and the consequence is that after the first remedy is given Sac. lac. finishes the cure. You can all do it, but you will not; you are not taught to do so. You alternate or you give three remedies, and what is the result? Your cases do not get along very much better than the allopaths. Any homœopath who goes in a new field will always have a lot of chronic cases and he makes his reputation on them. Why does he do it? Because he does not give so much medicine. He gives the system a chance to get well of the horrible drugging. That is why we don't stand shoulder to shoulder and there is so much dissension in our ranks. This paper of the doctor's has interested me very much, and as a result of this feeling that I have had regarding the teaching I was obliged to send my son to graduate at an allopathic institution, and today I could put him against any man in the room as to the results of prescribing. He has had special care, and the first thing I did was to take him through the Organon of Samuel Hahnemann—the very foundation upon which the structure exists. Unless a man carefully investigates and studies that Organon of Samuel Hahnemann he does not know the solid foundation which makes the homœopathic physician.

Dr. W. G. Dietz: The great work of the homœopathic physician is to select his remedy; that is one thing and that is a very important thing, but it does not end there. The administration of the remedy is the next thing, and I think after selecting the proper remedy, which is the similimum—that is the only remedy that is proper—when that is selected according to our best knowledge and belief—but there is no use of touching on the potency question, leave that aside. Be sure of your remedy and the potency will take care of itself. I never saw a man yet who knows the remedy, who knows the materia medica and knows the philosophy of Samuel Hahnemann, who would not keep his hands off and let the remedy alone when it commences to work. You see a case: Yes, the child was feverish last night! All night; I will give it some medicine. You give the child Aconite. A man is a fool who tells the patient what remedy he gives. Just like a man who told his patient, "I gave you Arsenic; that is just the remedy for your case." So in the afternoon the woman had a company. One of the ladies took a cup of tea. "Yes; the doctor was here today." "What is he giving you?" "Giving me Arsenic." "Arsenic? Arsenic—why, that is the worst poison under the sun!"

The woman sent word to the doctor that he need not come any more. Often people say, "What are you giving me?" I say, "What do you want to know that for? You are not coming to me to make a physician; if I know, it is enough; if you know that is one too many." But give a remedy, and when you know it is right and doing its work leave it alone, and especially so in chronic cases. We often give remedies more frequently than they are needed. The moment when the patients have improved, and in acute cases improvement should come inside of twenty-four hours, otherwise there is something wrong, let well enough alone. If no improvement sets in either the diagnosis or the remedy is wrong; or if the remedy is right the potency is wrong, because I think every man of any experience will admit that we have some cases in which different potencies will respond differently to different constitutions.

How many homœopathic physicians today have ever seen the Organon of Homœopathy or ever studied it? I venture to make this statement, and without successful contradiction, that not one-half of them have it, and the others are so dusty that they have not been touched. It is only by standing, as Dr. Thatcher has said, as do the allopaths, shoulder to shoulder, that the homœopaths will absolutely be united on their principles. They should stand firm on the rock which is firm and will not fail, and that is the law of similars. There is no contradiction; there is no backing down. If he does not believe it, he should stand up and say, "I do not believe it." If you are a man, be a man; if you are a Republican, be one; if you are a Democrat, be one; if a homœopath, be one, and I stand on that platform.

Dr. E. M. Gramm: It seems to me that the students when they leave the college are at times criticised much too severely for not being able to prescribe homœopathically, prescribe well and prescribe truly. As the capstone is to the arch, so is a knowledge of homœopathy to the fabric of medicine, and you certainly cannot have a journeyman fashion a true capstone and put it in place when he starts. You must give him time. And we fail as homœopathic physicians to prescribe properly because we do not go into the homœopathic materia medica deeply enough.

The students need to learn the science of medicine; and they need to know the science of homœopathy. It is the only law for prescribing for disease, but they must have the foundation. The men who have studied allopathy are the men who have found that physiological action of medicines is so and so, and they have learned that upon

the sick. We have found that the physiological action on medicine is injurious. Then they turn to the study of true homœopathy. But they first know how medicines act, and how they first act; they act injuriously when given in physiological doses. The fact is not with the teaching, but with the comparison.

How many homœopathic offices are filled with all sorts of samples? These samples are given to them by manufacturing chemists, and each is supposed to be good for a whole string of diseases. They are supposed to be the result of the best thought of the chemist, and that is only what they are, the best thought of the chemist. What do our men do? They just hanker for a case to try it on. They do get a case, and they think "Mr. Jones is a nice fellow; he gave me a good cigar; said it was good for this sort of a case and I will give it." It certainly saves time.

That is the reason our men fail to prescribe homœopathically. That is why they stray away from the pure homœopathic treatment. They are all the time reading all the circulars that come in and hanker for a case to come along to try it on. There is no cure that is as permanent, no cure that progresses as steadily as the one produced when you get the properly indicated homœopathic remedy. Our men should be taught and are taught that, but you cannot leave out of the question the whole fabric of medicine. When I went to college two years would graduate us. What can we learn in two years? As Dr. Mohr says, in those days homœopathic materia medica was dwelt upon in greater proportionate length of time during each college course. Homœopathic materia medica is dwelt upon just as strongly, just as well, but you cannot take a student and furnish him with all the knowledge necessary to give him such a position as we had when we graduated and yet give the same proportion of time to the homœopathic materia medica. The student needs to dig; he does not. The first thing is that they get as much pleasure out of life as they can, and bother but little with books, and that is the reason why manufacturing chemists reap such a harvest and the doctors carry around with them Colchicine and other medicines for rheumatism instead of studying up their cases. The law is all right. The fault is with us. You cannot expect the journeyman in practice put in place the capstone of the fabric of medicine at the outset of his career, you must give him time. Ability to do that comes only by close application and hard study, only comes after a person knows how remedies act, not only homœopathically but physiologically. If you have ever seen a case of opium poisoning you will know the indications for

Opium, and the same with Strychnine, and so with the other remedies in the materia medica. The old school physicians who have turned homœopathists have learned by practical observation of the action of remedies. We learn theoretically. We are compelled to carry two pictures in our mind: In the allopathic one we have the picture of the physiological action of remedies and in the picture of homœopathy we carry their dynamic action, but pictures are not nearly so impressive as real facts, as, for instance, when you see the bad and long-continued effect of drugs administered by yourself.

The student should not be criticised for not knowing certain symptoms, for not knowing certain things that come to them after they get within the pale of medicine. After you get an idea how a certain remedy acts, as rays from the centre, the indications radiate from that centre, the physiological action. The students must learn the important symptoms of a remedy—the pith of it first—and then the others come. But that knowledge cannot be gotten except by close application.

Dr. T. M. Johnson: What has struck me the last few years, coming into contact with new men coming out of college, has been their stupendous and erudite knowledge, physiological knowledge—I was awed by it. I doubt not what has been said in defense. The charge is true that they have been taught pure materia medica, but they have been taught so much that is not true that their heads are full of that.

Dr. A. P. Bowie: It is not to be supposed that a doctor who has just commenced his medical career should be as well informed in materia medica as Dr. Martin, after his long experience; but, at the same time, he should have enough knowledge to know how to select the homœopathic remedy. There is a way of selecting the homœopathic remedy, and that way is laid down in the Organon of the healing art, and that is what should be his guide instead of errors that he gets from his teachers. What is to hinder a young doctor from taking his case as laid down there, taking the symptoms of that case and comparing them with the materia medica? That is what he should do to select the remedy. When a man like Professor Constantine Hering—a man who knew more materia medica than any of us, or all combined, will know—a man like he who has taken and studied his case—he would study it today—perhaps he would have the patient come tomorrow and take some more symptoms; then he would not be satisfied and would see the case again the next day and study that case. At last he arrived at the remedy; he gave it and the result was all that could be desired. I think the trouble with us is we are

afraid to go to our materia medica; we are afraid to be seen studying our materia medica; we are afraid to have it by our side and look up our case. A lawyer does not take up a case without looking up precedent and law. Why should a doctor be afraid of looking at his books?

Dr. Dietz mentioned something which I learned long ago, never to give the name of a remedy to a patient. I had a sad experience in that line once. When I was a student of medicine, a friend of mine wanted me, before I commenced practice, to treat him, after I got to be a doctor. I took his case, read up the symptoms from Lippe's Materia Medica, and while I was waiting on some other patients he looked over Lippe's Materia Medica also. I selected a remedy according to that materia medica; it was Natrum muriaticum. It was a very dangerous drug. I gave it to the patient in the 30th potency. In a few days he came back and had some other symptoms. I took out my materia medica. "Well," I said, "these symptoms are contained in that drug, so just go on with that remedy." The symptoms he complained of were sleeplessness, bad dreams, and so on. The fellow finally got worse, he could not sleep and he came into my office one day and he said that he would study a little materia medica; so he takes this book of mine and he reads over Natrum muriaticum, and he had all the symptoms he read. He tears out the page that had the sleep symptoms on, sticks that in his pocket and goes away. Afterwards he became a hypochondriac and monomaniac on the subject, and he told it all around that I had taken away his sleep by this powerful medicine and the result was that it had a bad effect on him. But ever since then I never told a patient what remedy I gave, because it did him no good, but did him harm, and, at the same time, the remedy was just as innocent as it could be. Let us study our materia medica, and that is the way it will come, not as a lost art, but a living reality.

PHYTOLACCA DECANDRA; POKE.

R. P. MERCER, M. D., CHESTER.

THE first attempt at a proving of Phytolacca that I have ever been able to find was made in the summer of 1860 by myself. I was then a student at the old Filbert Street College, expecting to come up for graduation the following winter or spring, and was becoming anxious about material for a thesis, the requirements at that being "fifteen pages of original matter written on thesis paper of large size."

The original notes of this fragmentary proving I am unable to find at present, although I still have them somewhere. The pathogenetic symptoms were, however, too few to serve the purpose for which they were intended, and the proving was given up for another, and finally biliary calculi chosen, a subject of which I knew less, but wrote more. The symptoms which I obtained from my proving of Phytolacca were, however, given to my class, which gave it an introduction, and a recognition in the first edition of Hale's New Remedies.

The tincture used was made from the fresh root, gathered in July, sliced, bruised and marcerated in alcohol for two weeks before using.

While preparing the root, my eyes became congested, the lids swollen, and I had a sensation as if the eye-balls were covered with mucus. The next morning my eyelids were œdematous and agglutinated. I also had a stuffed-up feeling in the nose, as after a suppressed coryza.

The symptoms procured from five to ten-drop doses of the tincture taken three times a day for five days were: A feeling of fullness in the throat over the thyroid gland, as of something lodged there that should be swallowed, or in some way gotten rid of. A feeling as of a lump in the throat, very annoying, a dry irritation in larynx and fauces, with a sensation as if being scraped; a soreness and scraped feeling in the pharynx all the time. Tonsils somewhat swollen and œdematus. Throat relieved by swallowing food; headache with a feeling of weariness, and a feeling of discomfort in the legs, shin bones, and feet. Later there was a looseness of the bowels. Cough induced by a desire to get rid of the lump in the throat. Most of these symptoms lasted for several days after the drug was stopped, but in a less degree.

The symptoms procured in this feeble attempt at proving are all genuine drug effects, and as indelibly stamped upon my memory as though I had but recently felt them.

Several more extended provings have since been made, all of which confirm the throat symptoms and show a much wider range of action, lost to me by reason of my timidity.

The range of action of Phytolacca, however, from this and later provings would seem to be principally upon the eyes, nose and throat, the glandular system in general, and the thyroid and mammary glands in particular, upon the genitalia and the periosteum. Its action upon the mucous membrane is quite like Mercury or the Iodide of potash. Like them it appears to cause a condition approaching a false membrane in the throat.

From a proving by Dr. J. Lester Keep, of the class of '60, made soon after he left college, we have the characteristic feeling of a plug in the throat, a burning in the nose, a burning and dryness in the throat, which soon became a soreness; a thin watery discharge from the nostrils, which increased and became thicker, until the nose was stuffed up; headache in the frontal region and extending back; difficulty in swallowing; every attempt to swallow was attended by shooting pains toward both ears; increased secretion of saliva; difficulty in breathing; prostration.

Dr. Keep extolled it highly in an epidemic of influenza then prevailing, and in diphtheritic sore throat; which is a sore throat, you all know, that for business reasons we would like to call diphtheria, but for professional reasons we dare not.

It is thought by some to have a marked influence upon muscular tissue, but the pains which it produces are not muscular. They are deeper seated, periosteal pain—again like Mercury or Iodide of potash. This will account for the prompt relief following its use in syphilitic rheumatism, or mercurio-syphilitic affliction, so many cases of which used long ago to come to us from the old calomel doctors.

A prompt and effectual cure, with Phytolacca, of a case of this kind—"mercurio-syphilitic rheumatism"—you will find in Volume 1, Hahnemann Monthly, reported by myself in 1866.

It seems to have but slight effect upon the vascular system, none of the provers having noted any marked symptoms. One or two had occasional shocks of pain in the region of the heart, but the glandular system is most markedly affected. A peculiar tension and pressure in the parotid glands, hardness and swelling of the cervical

glands, a hard painful swelling of the breasts was experienced by several provers.

Clinical experience has confirmed its specific affinity for the mammary glands by its prompt relief of the hard tense swelling of the breasts after confinement. In indurated swelling suggesting cancer of the breast it has a decided curative effect.

A marked characteristic of Phytolacca is the sensation of a plug in the throat. It is present in almost every case of throat trouble calling for its use, probably caused by its action upon the thyroid. The cough which it causes, which is sometimes constant and greatly annoying, is induced by a desire to get rid of the sensation of fullness, a plug in the throat. Another characteristic is the absence of heat in the swollen gland or part affected. A cold swelling.

I do not know that any proving has been pushed to the extent of producing any decided manifestation of ulceration. But in my clinical experience it has repeatedly cured both syphilitic and scrofulous ulcers and their accompanying conditions.

Before the Iodide of potash came into such general use in secondary syphilis it has served me many a good turn, not only in clearing up the constitutional and local effects of syphilis, but the effects of the murcurial disease often left in its place. Indeed I am quite convinced that the judicious use of Phytolacca in secondary syphilis is quite as homœopathic and much to be preferred to the general abuse of the Iodide of potash so much in vogue at the present time.

DISCUSSION.

Dr. W. J. Martin: We are getting every subject talked about this afternoon. Here is a man who forty years ago commenced investigating the use of Phytolacca, and that resulted in a discovery and in the use successfully of that remedy, according to and on the lines of homœopathic investigation and application, in the treatment of ulcers, syphilitic and otherwise. Is that taught in our colleges as a rule? Students come up and the only one thing they know for syphilitic ulcer is the saturated solution of Iodide of potash; that is all they know.

Dr. Charles Mohr: That is not all they are taught.

Dr. W. J. Martin: That is all they remember.

MERCURY IN SYPHILIS.

C. S. MIDDLETON, M. D., PHILADELPHIA.

As the writer is a firm believer in the principles of homœopathy, which necessitates a corresponding belief in the efficacy of homœopathic remedies in curing diseases homœopathically, that must be his excuse for "threshing old straw."

Recent literature in this line, as well as some expressions in discussion at the late meeting of the American Institute of Homœopathy at Washington, lead the writer to make an effort to dispel, not medical darkness, nor ignorance, shall I say, but unwarranted prejudice. It seems to be deeply rooted in the minds of some practitioners that to use Mercury for anything, especially for syphilis, is an evil for which they dare not hold themselves responsible. Because Theophrastus alludes to Mercury about 300 years B. C., and because it has played a more or less important part in medicine since the beginning of the sixteenth century, accompanied with its marvelous abuse, there is no reason for fear making it our servant, since Hahnemann taught us how to prescribe it when indicated. The value of Mercury in this one disease should be a most convincing argument for the proof of the law of *Similia* on the part of the homœopath and the acceptance of the proof by the old school on the other hand.

The fact that Mercury was prescribed by both schools for the same disease was one of the problems in medicine which seemed difficult of explanation to the writer when he was a student, until he realized that many cures were made by the old school by remedies, while not intentionally prescribed upon the basis of the similars, yet they were nevertheless sometimes so adapted and cures followed.

No disease, perhaps, is more pronounced than syphilis; the pictures in its present and possible sequences are not only easily recognizable as seen, but in the mind's eye as to what, in many cases, may yet come. How little would one be supposed to know of this disease if, upon the presentation to him of an initial chancre a few days old, he were to promise its disappearance in a week instead of about six weeks, with the possible sequences in mental view besides?

What other disease, save perhaps tuberculosis, has such a far-reaching effect, attacking any or all tissues of the body at pleasure, and whose devastating effects may last through life continuously;

or perhaps after a long period of quiescence and happy years of apparent safety break out afresh and torture the victim still more?

A case of this latter feature comes forcibly to my mind when, after more than twenty years, a violent and destructive ulceration of the epiglottis supervened which would soon have destroyed that organ and of course passed on to the larynx with its attendant evil, which was cut short, as if by some magic, with appreciable doses of the IX trit. of Mercurius sublimatus corrosivus frequently repeated. In comparing the deep-seated, general, destructive and long-lasting character of syphilis with the characteristic and corresponding action of Mercury can any one fail to be impressed by the similarities? What tissues or organs of the body withstand the destructive action of syphilis, or Mercury, if the latter be given in such a manner favorable to produce such a result?

Be it the initial ulceration of the chancre, the secondary eruption, mucous patches in the mouth and throat, gummata, etc., and later destruction of bone and cartilage, or nerve disintegration, we still have the similarity of action in Mercury more closely than in any other one remedy.

It is just here, in comparing the disease picture under consideration and the early action of the remedy, that I wish to drop an idea, not at all new, but one which many disapprove; that is, if we could anticipate the development of diseases in certain directions, and "cut off," so to speak, such developments to the extremes they sometimes go, we could often shorten the attack and course and thus cure the patient more quickly.

Indeed, I believe many of us really do this more or less unconsciously, knowing, as we sometimes do, that when a remedy has produced certain favorable results it is time to discontinue its use and substitute another which "follows" best to complete the cure by forestalling expected developments, and which will be most likely to meet the requirements of the next stage of the disease.

This idea applies so forcibly in syphilis and Mercury that in knowing so well the course which the disease will take if left to itself, and even when sometimes modified by treatment, and knowing the action of Mercury upon the system, we are enabled to know that we are anticipating the necessities of the case, in this instance, in *not* discontinuing the remedy.

It seems to the writer but sheer folly and, indeed, great injustice to treat the patient, as was expressed in a discussion recently heard, with remedies totally inadequate to eliminate the disease, such as

Nux vomica, Chamomilla, Pulsatilla, etc., because they were to the mind of the prescriber the indicated remedy for some collateral or imaginary ailment the patient had chosen to express, losing sight of far more important symptoms which constitute the disease, and which, if neglected or abandoned, will be at the expense of the patient from more than one standpoint.

In regarding syphilis as a disease peculiar to itself, and without affinitive relationship, we have less necessity for intercurrent or collateral prescribing than in many other conditions; it is a long and tolerably straight road to travel, and you will lose less time for your patient, get better results, and give better satisfaction to him and his posterity if you avoid the by-ways and stick to the "indicated" remedy.

Now I do not wish to be misunderstood. I do not think Mercury is the only remedy for syphilis, but that it approaches more nearly a specific for it than any other drug is clear to my mind. Neither do I wish to be accused of recommending a remedy for it regardless of indications, for it is just here that we claim the greater superiority for Mercury, the greater accuracy of indications for the disease.

It is not the intention of the writer to compile a comparison of the disease and the symptoms of Mercury, that is already done in the text-books; but the intention has been to try to brush away some of the prejudice existing in the minds of many practitioners as to the value of Mercury in syphilis, because (according to declarations of some men to whom I have listened) they think some immaterial remedy has some prominent symptoms, and which may remove a few immaterial symptoms, while the syphilitic poison is still working havoc in the patient's system.

In conclusion, I would say that *my* best results have been, firstly, when the patient has come under my care at the earliest moment, and, secondly, by the use of Mercurius solubilis Hahnemannian, IX trituration, 2 grains every four hours; this is kept "going" for weeks at a time, modifying its use but little until the chancre shows signs of healing, which is taken for granted that the beneficial effect of the remedy is being manifested. I have never salivated a patient in my life by such a course, and on the other hand, the writer can point to a number thus treated from the earliest manifestations of the chancre absolutely without secondary symptoms; some of the men have been under observation for years, married and become fathers; those children are still under observation, without a trace of inherited syphilis. This has been my practice for nearly forty years, and I see no reason

to change my treatment of these cases. When cases come to me who have had too much Mercury, which is sometimes the case when leaving the old school, other remedies are required, such as Potassium iodide, Hepar sulphur, Nitric acid, Thuja occidentalis, etc.

THE RELATION OF PATHOLOGY TO HOMŒOPATHIC THERAPY.

CHARLES MOHR, M. D., PHILADELPHIA.

A RECENT writer in the *Journal of Medicine and Science* says of Hahnemann that to him "belong, with other things, the theories of similars and infinitesimals in therapeutics. Apparent symptoms were made the groundwork of treatment, and a knowledge of pathology was considered unnecessary. The term 'symptom,' without reference to a condition causing the manifestation, is a meaningless misnomer; and symptoms, so-called, without proper reference to an underlying condition, are necessarily poor guides for any treatment which, properly directed, would be of value. The system has seemingly shown a wonderful tenacity of life, but the strength of endurance has been more apparent than real. The name of the system remains principally as a trade-mark in business, while the original practice has mainly departed. It is possible, however, that some adherents to the system may still be found so far in the rear as in practice to hold to the original tenets of the school, but to find them is hardly worth the searching. The term 'new school,' which is sometimes heard, is here a ridiculous absurdity."

It is thus that "our friends, the enemy," speak of homœopathic practitioners; and little wonder, as there are so few of the latter willing to stand by their colors. Indeed, one frequently hears, in our own society discussions, slurs on those who still believe and practice according to Hahnemann's tenets, as though they were little more than "symptom coverers."

Hahnemann attacked the pathology of his day, as well he might, as an indication for medical treatment, and hurled his anathemas against the prevailing habit of forcing "the evacuation of some material morbific substance, as well as of several kinds of fictitious humors, alleged to form the basis of diseases." (*Organon*, p. 23.) Hahnemann did believe in "sick physiology," but he did not believe

in the theoretical explanations offered by the pathologists of his and former days as to the changes in tissues, fluid and solid, which were the cause of the various diseases of mankind. He denounced "revolutionary (revulsive) treatment, *possessing no direct immediate pathological bearing upon the structures primarily affected.*" (*Organon,* p. 29.)

When Hahnemann saw how vague the shifting theories and hypotheses of the pathologists were, and how pernicious the means employed to cure the sick; and, later, when he had satisfied himself that there was a law of cure, expressed by the well-known Latin formula *Similia similibus curantur,* and under the law advised his followers to treat likes with likes (*Similia similibus curentur*), his aim was to insure simplicity and certainty.

Hahnemann was himself a theorist—we admit this; but above all he was intensely practical, and to him a fact was always a fact. If a drug was capable of curing a patient of a disease once, it was capable of curing any number of patients at any and all times, provided always the symptoms and conditions were identical.

Hahnemann did not, as the writer of the article quoted, ignore *conditions.* Indeed, any one familiar with Hahnemann's works finds abundant evidence that such was not the case. What more plain than his assertion in Section 70 of *The Organon,* that a physician must regard as curable in diseases "all the complaints of the patient, *and the morbid changes of his health perceptible to the senses.*" In Section 186 local diseases are referred to, and affections of external parts requiring mechanical skill, properly belonging to surgery, and in cases "when external impediments are to be removed that prevent the vital force from accomplishing the cure. Examples of this kind are: reduction of dislocations; the union of edges of wounds by bandages; the extraction of foreign bodies that have penetrated parts of the body; the opening of cavities, either for the removal of cumbersome substances or to form an outlet to effusions; the approximation of fractured ends of bones, and the retention of the adjusted parts by proper bandages, etc." In Section 192 we find Hahnemann saying that the homœopathic medicine to act effectually on acute local disease must be selected "by conducting the examination of a case in such a manner that the record of the exact state of the *local disease* is added to the summary of all symptoms and other peculiarities to be observed in the *general condition* of the patient."

It seems to me this is getting at the pathology pretty thoroughly, and is the method employed by all practitioners of Hahnemannian

homœopathy who are deserving of the name. I know there are physicians of our school who rightly believe that the anatomical lesion alone gave no indication for drug therapeutics in Hahnemann's philosophy; and there are others again who wrongly believe that the subjective phenomena were all that Hahnemann took into consideration in treating the sick.

There are still too many homœopathic practitioners who make a single objective symptom and its nearest organic origin the basis of therapeutics; they endeavor to match an anatomical structural change by a drug supposedly capable of producing a like pathological product. They apply the remedy to a disease rather than to a patient. Witness the too common practice of prescribing Phosphorus because a patient has an inflamed lung. Similarities like these are alluring, but the fascination leads men to follow Paracelsus and Rademacher rather than Hahnemann. It is far better never to rest content with identity of lesion, or with identity of seat between disease and drug; we should aim also at making their kind of action the same, and this can only be done by securing similarity in their symptoms and conditions.

Then, again, we find other practitioners of homœopathy satisfied to prescribe, on some one peculiar subjective sensation, a drug the pathogenesis of which shows an identical peculiar subjective sensation. Hahnemann himself cautions us in the *Organon* against being misled by such persistent single symptoms, however peculiar or individual. Sometimes, too, a prominent and peculiar symptom is the result of some removable cause, and no matter how near the symptom is matched by a drug, it continues until the *cause* is removed. The drug was not indicated. Hahnemann taught us to remove the cause by whatever means were necessary.

Misconception in the application of therapeutics would be readily removed if physicians would properly estimate the meaning of terms. Ordinarily Physiology is defined as the science of health, or normal life; Pathology as the science of disease, or abnormal life; and Therapeutics as the science of curing diseases. Generally, if the physician of the ordinary kind cannot demonstrate the *physical* presence of something abnormal, he concludes that there is no disease, hence no need of therapeutics; and generally, again, if the physician of the ordinary kind can demonstrate a lesion, he concludes that by adapting a remedy to the product of the disease he is treating the disease. To the well-qualified practitioner, who may be designated as the extraordinary physician, how different his efforts in the science of thera-

peutics if he believes, as Hahnemann did, in a pathology totally distinct from that which only recognizes pathological anatomy. He adapts a remedy to the totality of symptoms, even though, as is so frequently the case, no structural change in tissues or organs can be discovered by the means at his command; the symptoms may be altogether subjective. He treats a patient, not a disease. That Hahnemann and his true followers are not alone in the recognition of such cases, let us hear the words of a celebrated old school authority. Dr. Russell Reynolds, before the British Medical Association, pleaded most eloquently as follows: "Is it not coming to this, that but little attention is often paid to the accounts which patients give of themselves, their ideas, emotions, feelings, and physical sensations? These are things which we cannot weigh in our most guarded balances; measure by our finest scales; split up by our crucibles; or describe in any terms save those which are peculiar to themselves, and which we cannot decompose. These symptoms are often disregarded and set aside; and the patient whose story of disease is made of them is often thought fanciful, hypochondriacal, hysterical, nervous or unreal—because, forsooth, we have physically examined thorax, abdomen, limbs, and excretions, and have found in them nothing wrong; because we have looked at the retinæ, examined the limbs electrically, traced on paper the beatings of the pulse, weighed the patient and not found him wanting. Still he is miserable, in spite of placebo and assurance that there is nothing organically wrong! There may be in him a consciousness of deep unrest; or of a failing power which he feels, but cannot see; or of something worse than pain, a sense of impending evil that he is conscious of in brain or heart; a want of the feeling of intellectual grasp, which he may call failure of memory, but which memory—when we test it—seems free from fault; a want of the sense of capacity for physical exertion, which seems, when we see him walk or run, to be a mere delusive notion, for he can do either well or easily to our eyes or those of others; and so he is called nervous, and is told to do this or that, and disregard these warnings which come to him from the very centre of his life. And let me ask whether or no it has not again and again happened in the course of such a history as that which I have only faintly sketched, that some terrible catastrophe has occurred? Do we not see gradually breaking down while we say there is no organic change in the brain?—hearts suddenly cease to do their work when, after careful auscultation, we have said there was naught to fear? Suicide or sudden death sometimes disturbs the calm surface of our scientific

prognosis of no evil; we may be startled, and then may see all that we ought to have seen before. But when the ripples that such unforeseen events have occasioned on that smooth surface have subsided, we go on as we have already done, and still pay but little attention to what the patient feels, and delight ourselves in the precision of our knowledge with regard to physical conditions of which we may know nothing and may care still less. No one can appreciate more highly than I do the value of precise observation, but I do not believe that minute, delicate and precise observation is limited to a class of facts that can be counted, measured or weighed. No one can see more distinctly than I do the wrong conclusions to which a physician may arrive by accepting as true the interpretations which fanciful patients may offer of their symptoms; but I am sure that if we pay no heed to those mistaken notions of a suffering man, we lose our clue to the comprehension of the real nature of his malady. Morbid sensations and wrong notions are integral parts of the disease we have to study as a whole, and we are bound to interpret their value for ourselves; but we can ill afford to set them aside, when we are as yet but in the dawn of scientific pathology, and are endeavoring to clear away the obstacles that hide the truths we hope hereafter to see more clearly about the mystery of disordered life. The value of such symptoms may be slight in some kinds of disease, when compared with that of those phenomena which may be directly observed; but we are bound to remember that there are many affections of which they furnish the earliest indications, and there are not a few of which they are throughout the only sign."

On the other hand, the extraordinary physician again, who recognizes that pathology is the science of morbid processes and functions, and that pathological anatomy is the science of morbid organs and tissues, is in a position to exercise the functions of the therapeutist most satisfactorily. He clearly recognizes the "totality of symptoms" and conditions, so much insisted on by Hahnemann as giving the indications for the administration of the "similar remedy." Take a pneumonia as a familiar example. What rational physician, what true homœopathist, would think of taking the structural changes in the lung alone as an indication for medicinal treatment? The morbid processes and deranged functions which present themselves give the true and unfailing indications for drug therapeusis. The fever, the flushed or red cheek, the rapid pulse, the relatively more rapid respirations, the chest pains, the painful cough with its bloody or rusty and sticky sputum, the delirium, the feeble heart with its dis-

tant heart-sounds;—all these, together with certain ameliorations and aggravations, are a complex of symptoms taken into consideration by the Hahnemann prescriber, and to these he directs his therapeutic measures, giving that single remedy whose pathogenesis shows the nearest resemblance to the aggregate of the disease phenomena. As it is with so common a disease as pneumonia, so it is with all other affections, whether of dynamic, infectious or microbic origin.

We may all profit by the sage remarks, bearing on the questions discussed in this paper, quoted from a celebrated old school authority. Sir Andrew Clark, in his Presidential address before the Clinical Society of London, said: "Another great work of our society has been, and continues to be, the gradual unfolding of the exact relations which morbid anatomy and, incidentally, experimental pathology, should hold to clinical medicine. These two servants of our art, excited and carried away by their marvelous successes, and assuming a joint sovereignty over our art, look down with a condescending superiority upon clinical medicine, ridicule her claims to supremacy, scoff at her empirical distinctions, reproach her with being unscientific, and strive to torture her into a slavish subjection to their theories. But the true relation is not this; it is, indeed, the converse of it. For the structural change is not disease; it is not coextensive with disease; and even in those cases where the alliance appears the closest, the statical or anatomical alteration is but one of other effects of physiological forces, which, acting under unphysiological conditions, constitute by this new departure the essential and true disease. For disease in its primary condition and intimate nature is in strict language dynamic; it precedes, underlies, evolves, determines, embraces, transcends and rules the anatomical state. It may consist of mere changes of the relations of parts, of rearrangement of atomic groupings, of recurring cycles of vicious chemical substitutions and exchanges, of new conditions in the evolution and distribution of nerve force, and any or all of them be invisible to the eye, inseparable from life and undiscernible in death. Undoubtedly the appearance of a structural alteration in the course of disease introduces a new order of events, sets in action new combinations of forces, and creates disturbances which must be reckoned with, even as mechanical accidents of the pathological processes. But always behind the statical lies the dynamic condition; underneath the structural forms are the active changes which give them birth, and stretching far beyond the limits of pathological anatomy, and pervaded by the action and interaction of multitudinous forces, there is a region

teeming with manifold forms of disease unconnected with structural change and demanding the investigation which it would abundantly reward. It is in this mysterious and fertile region of dynamic pathogenesis that we come face to face with the primitive manifestations of disease, and learn how much knowledge from various sources is needed to understand it aright; it is here that we see how, without help from physics, chemistry and biology, collecting, converging, and meeting in a common light, no single problem in disease can be completely solved; it is here that we are made to comprehend how the nature of a pathological product cannot be determined by its structural character, but by the life history of the processes of which it is only a partial expression; it is here that we observe how, in therapeutic experiments, the laws of the race are conditioned and even traversed by the laws of the individual."

In these later days much attention is given to the study of pathological anatomy and to experimental pathology, and this is as it should be; but there should be at the same time a proper estimation of the good such knowledge can be to the therapeutist, and homœopathic practitioners should least of all, as we have seen, ignore the value of all such study. On the other hand, much more attention than is given should be directed to experimental pharmacology. We want more provings, especially of the many new drugs introduced since Hahnemann's day. We want the provings conducted in such manner that no doubt can be entertained as to the validity of the pathogeneses published for therapeutic uses. In the study of pathology we want to know what is behind the disease product. In the application of therapeutics we must know all there is to treat, before we can apply a medicine.

DIGITALIS.

C. S. SCHWENK, M. D., PHILADELPHIA.

Digitalis is a dangerous drug, and may only be used with safety when guided to its selection by the symptoms of the case. Through irritation of the pneumogastric nerves we pass out into the long train of Digitalis symptoms.

There is an increase of arterial tension, perhaps due to stimulation of the vaso-motor centre, making the pulse primarily strong, but quickly followed by slow, weak, imperfect pulse due to striated and

non-striated muscular tissue becoming affected; and as these tissues weaken, dilatation of the heart takes place. In consequence, we can naturally anticipate the line of symptoms such a drug would manifest.

A very pale face, bluish lips and finger nails, sickly expression, bluish hue under pale skin, not only the face, but the skin over the whole body would naturally be pale and bluish, the pulse being slow and weak.

When the normal arterial tension has gone, naturally functional disturbances take place in the different organs.

Passive congestion of lungs, depending on a weakened dilated heart. Suppressed menses with cough, and vicarious menstruation from lungs.

Great weakness of genitals.

Dropsy with suppression of urine. Faintness or sinking at stomach, as if he would die, with deathly nausea and vomiting.

Respiration irregular and performed by frequent deep sighs.

Respiration difficult and slow, with constant desire to take a very deep breath; distressing dyspnœa and fear of suffocation. Hollow, deep, spasmodic cough. Faintness, exhaustion and extreme prostration.

Tenderness in region of liver.

Nausea and vomiting. Feeling of sinking at the stomach, as though one would die. Nausea not relieved by vomiting.

Symptoms of jaundice.

Thirst with desire for some drinks.

White, pipe-stem stools.

With our knowledge of the physiological action of the drug, and the symptoms characteristic of it given, should make its selection a very easy matter. When Digitalis is called for the heart symptoms in varying degrees are always present in corroboration of the other symptoms.

CONVALLARIA.

ROLAND T. WHITE, M. D., ALLEGHENY.

CONVALLARIA MAJALIS, more commonly known as the graceful, modest and sweet-scented lily of the valley, derives its name from Convallis, "A Valley," and majalis, belonging to the month of May.

Traditionally enshrined in legion, while disseminating with its perfume not only gentle sentiment but per se the dynamis for the over-burdened heart.

Convallaria is usually described as a cardiac stimulant, diuretic and cathartic, large doses causing vomiting and collapse, with irregularity of the heart action, first slower, afterwards becoming accelerated.

Compared with Digitalis, Strophanthus and Cratægus, unlike Digitalis, Convallaria manifests no cumulative effects. Digitalis will usually aggravate those cases which, with weak, irregular hesitation of the heart, we find an extreme irritability and uncontrollable nervous erethism.

This mental phenomenon arising from the troublesome dyspnœa is especially indicative of Convallaria.

The general medicinal properties of Convallaria are attributed to two glucosides, namely, Canvallaria, a purgative, "without effect upon the circulation," and Convallarin, an active cardiac stimulant, in poisonous doses seems to primarily affect the vagi nerves, arresting the heart in systole." "Compare strophanthin." The whole plant is commonly used, but I am led to believe greatest reliance may be placed upon a tincture or infusion made from the flowers alone.

The diuretic action of Convallaria is not so pronounced where œdema is primarily due to nephritic affections, especially contracting kidney, "with the frequent accompanying dyspnœa, cardiac dilatation, etc.," distinguishing it from Digitalis, which so promptly increases arterial pressure in these cases.

We find in Convallaria distinctly a cardiac stimulant, much slower and less active than either Digitalis or Strophanthus, often taking several days of continuous exhibition before its complete medicinal effects are manifest, its action, however, continuing for a protracted period after administration has ceased.

In a considerable portion of these irritable hearts, which are characterized "by irregularity, second sound exceedingly weak or often

hardly perceptible, left ventricle dilated through mitral insufficiency, troublesome palpitation with great dyspnœa recurring in paroxysms, the mental condition irritable and querulous," Convallaria will not only kindly ameliorate and modify, but even in advanced cases where debility and more or less anasarca have ensued marked improvement can be expected, and with proper bathing, hygienic attention and careful diet the patient may be so far restored as to resume light occupation and relinquish all medication.

In some of the functional derangements of the circulation Convallaria will be found very useful, i. e., nervous palpitation, with catching of the breath and excitement, the patient plaintively irritable, no complaint of actual pain about the præcordia, the embarrassment arising from vaso-motor disturbance.

Convallaria has a broader field of usefulness than is generally realized, although it may not change the status present. In organic affections it meets an equivalent in its assistance to compensation when nature seems to have exhausted her energies and is ready to give up the battle; this restoration is more or less stable after the administration of the remedy has ceased.

In connection with the cardiac signs, whether functional or organic, the excessive nervous phenomena may serve a ready guide in the selection of Convallaria. These are characterized in reflex irritability, anxiety, restlessness, insomnia, and nervous erethism, even to hysteria.

REPORT OF THE

SECTION OF PÆDOLOGY.

Diabetes Mellitus, by Anna C. Clarke, M. D.
Dentition, by W. H. Bigler, M. D.
Intubation of the Larynx in Diphtheritic Laryngitis, by J. D. Boileau, M. D.
Personal Experience with Antitoxin in Diphtheria, by F. D. Brewster, M. D.
Scarlatina, by M. J. Holben, M. D.
Rachitis, by D. S. Kistler, M. D.
Intestinal Irrigation in Infantile Diarrhœa, by John L. Redman, M. D.
Cholera Infantum, by J. H. Sandel, M. D.

DIABETES MELLITUS.

ANNA C. CLARKE, M. D., SCRANTON.

On looking up this subject, I find that Parry reports 1,360 cases of diabetes, with only eight below ten years of age, and of the 700 cases reported by Prout only one was under ten, while Myers reports 380 and only one below ten years. Lewis Smith, in "Diseases of Children," does not consider the disease. It may be that more cases would be reported if more attention were paid to urinary trouble in children. The case which I am about to report I thought might waken an interest to more carefully investigate the subject.

We had reason to be anxious for this child, as the mother when admitted to the Florence Mission in the fifth month of pregnancy was suffering from diabetes. She was at once put on the usual diet and hygienic treatment. Arsenicum album 3x was given four times per day, with some improvement; however, she was in bed for the three weeks previous to labor. Labor was uneventful, except for a slight laceration of the cervix.

The child, a boy, weighed 8 pounds, and was well formed; apparently healthy. There was a phimosis, but circumcision was not permitted. The prepuce was stretched, which temporarily overcame the difficulty. The mother's milk was deficient in fats, and the child was not allowed to nurse. A healthy mother with a babe of the same age

volunteered to nurse the child and was allowed to do so. The child did not thrive. An examination of the urine was negative. The child suffered from stomatitis and gastro-intestinal disturbances, and it became necessary to change to modified cow's milk. There was some improvement, and the child left my care to return in about six months very thin and excessively irritable. It had been taking malted milk instead of the cow's milk. There was frequent and painful urination, and hoping to relieve one source of irritation the mother consented to circumcision, and Dr. McDonnell and I operated. Chloroform was used, and at the first breath the child collapsed, and it took about twenty minutes of heroic effort to resuscitate it.

The operation was finished without further trouble, and the wound healed without any difficulty. The child suffered from shock, but revived in about twenty-four hours and began to pass large quantities of urine and give evidence of intense thirst. There was no rise in temperature. The wound looked well. An examination of the urine showed about 5% of sugar. The amount of urine passed must have been as high as 15 to 18 pints per day. The flow was almost continuous. As water and milk and water gave no disturbance as much was given as the child could take. The milk taken went as high as 4 quarts, and as much more water in the twenty-four hours. A few times the stomach refused both the milk and water. At such times the suffering became extreme and was only relieved by weak saline injections per rectum.

The bladder a number of times refused to empty itself, and would become greatly distended. The catheter was passed and left in situ for from two to three hours, when the bladder apparently became rested and performed its function. This state of things had continued over two weeks, when I received a message saying the child had not passed urine in six hours and was becoming greatly bloated. I found the eyes closed by the great distention of the upper and lower lids. The lips were swollen so as to be everted, and the fingers were like little bladders. The head drawn back; breathing very rapid and shallow. The child did not respond to anything, the end seemed very near, but remembering that while there is life there is hope I placed the little sufferer under a tent and an alcohol steam bath was given. A cold cloth was put on the head and Vesicaria 1x given per mouth. The child had been in the bath about five minutes, when the kidneys began acting and in ten minutes there was a marked decrease in the bloating: the child was wrapped in flannel and the bath repeated every two hours for the next twenty-four.

The craving for drink markedly decreased and the child continued to improve. Arsenicum 3x had been the remedy given throughout the attack, and I continued it. In the course of a month the child had increased markedly in weight; the intense thirst had subsided, only two quarts of milk being taken per day, when we had an attack of bronchitis, which came near finishing the case, but it did not. The child was seen by me a few days ago and an examination of the urine made. Sp. gt. 1024; about 1% of sugar found. No casts.

The child seems mentally bright, looks prematurely old, weighs 16 pounds.

The teeth have been slow in coming and each eruption has aggravated the case. Kali phosphoric 3x morning and night have controlled the nervous symptoms arising from this case. Otherwise the child has two doses per day of Arsenicum album, and I think we should be thankful for the results.

DENTITION.

W. H. BIGLER, M. D., PHILADELPHIA.

THE spirit of negation and contradiction, which has been so ruthlessly aggressive elsewhere during the last quarter of a century, has not failed to make its influence felt in medicine. Here, more than in other departments of knowledge, it seems but too often to be prompted by a desire to gain a little passing notoriety by an attack on truths or opinions which are based, not only upon careful observations of years, but upon equally as long clinical experience. The more widely accepted, and the more rational, the fact disputed or the opinion held, the more eclat is temporarily gained by their contradiction. We must not forget to take into account, too, the blind desire to apply universally the germ theory of disease, sometimes in absence of proof, often in spite of it.

One of the old-fashioned medical beliefs which has been attacked with a large share of ridicule by the iconoclasts is that which ascribes to the process of dentition a large part of the ailments befalling children between the ages of five months and two years. Arguing that the acquisition of teeth, being a physiological process, should not be attended by pathological symptoms, a number of physicians, many even authorities on the subject of children's diseases, are loth to trace any of these ailments to dentition, in spite of what, in any other case,

would be regarded as proof of the fact. In spite of this I am willing to be ranked with that large number which still finds in the process of dentition a very potent cause, either exciting or predisposing, of very many of the departures from health incident to that period.

"The opinion formerly entertained in the profession, and now prevalent in the community, that many infantile maladies arise directly or indirectly from dentition is erroneous. Some good observers say that dentition being strictly a physiological process, it should, like other such processes, be excluded from the domain of pathology."—(Smith.)

"The idea that the process of dentition occasions the various diseases with which it was formerly supposed to be associated is an erroneous one," so says Rotch, and yet a little further on, having enumerated some of the nervous disturbances accompanying dentition, he says: "These symptoms occur with such regularity at a time when a tooth is in its final stage of development, and cease so uniformly when the tooth has attained its growth, that the casual relation between the tooth and these nervous symptoms seems more than probable."

Holt says: "At the present time many good observers deny that dentition is ever a cause of symptoms in children; some even going so far as to say that the growth of the teeth causes no more symptoms than the growth of the hair." "Without doubt the usual mistake made in practice is in overlooking serious disease of the brain, kidney, lungs, stomach and intestines, because of the former belief that the child is "only teething."

He is now willing to admit that dentition may produce many reflex symptoms, some even of quite an alarming character.

The argument that, being a physiological process, dentition cannot be regarded as a cause of trouble leaves out of view two important considerations; first, it is a process which does not extend throughout life, but is concentrated, as it were, upon a comparatively short period, and is, therefore, more intense in its influence; secondly, physiological processes are not always innocent of producing results, not originally intended by nature. We have, no doubt, all in our day comforted the timid primipara with the assurance that childbearing is a physiological process, and, therefore, not to be dreaded, but in how many cases, even of perfectly normal labor, have we not been obliged to confess, at least to ourselves, that, physiological or not, the process was not without its drawbacks?

Again, even if physiological, see what a tax is imposed by it upon

the system. It would be manifestly unnecessary and out of place to enter, with any attempt at detail, into the physiology of dentition, but it will be of interest to recall a few facts, as concisely given by Rotch, which will help us to appreciate the demands made upon the nutritive and nervous systems of the infant during the acquisition of the new organs, the teeth.

"The development of the first set of teeth begins at about the seventh week of intra-uterine life, and, progressing slowly, is completed about the end of infancy. At birth the twenty embryo teeth, ten in each jaw, are so enclosed in the alveolar processes that nothing but the smooth mucous membrane is apparent on the gums above. Below they are connected with the branches of the inferior dental nerve (an important clinical fact to be remembered) through openings at the bottom of the alveolar processes. When calcification of the neck of the tooth begins, elongation also takes place, and, as the tooth is enclosed in bony walls below and on the side, it gradually grows through the point of least resistance, namely, the gum which covers the top of the alveolar processes. The continued pressure gradually causes atrophy of the mucous membrane, and the crown of the tooth appears on the edge of the gums. The various teeth come through the gums at times which are regulated according to their development, i. e., at times corresponding to the calcification of their roots and consequent elongation. This process usually takes place in groups, and with considerable regularity in the average normal infant. Variations both as to the order in which the teeth appear and in the time of their appearing are common."

I doubt whether any infant has ever "cut its teeth" without experiencing discomfort, to say the least, and without exhibiting symptoms of it, readily recognized by an observant nurse or mother. Calling to mind the far-reaching and often long-overlooked consequences which continued irritation of the nervous system are capable of producing, e. g., very slight degrees of astigmatism, we should be prepared to admit that dentition may show its effects upon the nervous system, even when the local symptoms may seem insignificant. This is rendered still more intelligible when we remember how readily the equilibrium of this system is disturbed in the early years of life.

The demand for certain elements which go to the formation of the teeth, and which must be supplied in the food and utilized through the normal powers of assimilation, will readily explain how easy it is for the nutritive system and therewith the well-being of any and every part of the body to be disturbed by the process of dentition.

I have merely wished to show by the foregoing that there is nothing irrational or unscientific in claiming a causal relation between a disturbance of health in a child occurring coincidently with dentition and that process, and demanding that in treatment this causative factor should always be met. The danger to be recognized and avoided is that of ascribing at once, without careful examination, to teething derangements of health in the child which may proceed from other causes. A good rule to follow is in all cases, where there is no local lesion apparent in the gums, to seek elsewhere than in dentition for the explanation of symptoms *first*, but not exclusively.

In healthy children, especially if breast fed, most of the teeth may be cut without any but the most trifling disturbances, such as irritability, salivation, etc., while in weakly infants, particularly if bottle fed, or in those who have inherited a neurasthenic constitution, the process of dentition is apt to be attended with severe if not dangerous symptoms.

The most common forms in which disturbed dentition is manifested are diarrhœa and convulsions.

It cannot be denied that the gastro-intestinal tract is more liable to be affected by fermentative diarrhœas during dentition than at any other time. For those who wish to emphasize the infectious nature of these troubles it is easy to explain this fact by the consideration that owing to the increased reflex irritability of this tract, brought about by the process of dentition, it becomes more susceptible to the inroads of external infection. There are cases in which the bowels become normal in their action as soon as the advancing tooth or teeth have pierced the gums. These are purely reflex diarrhœas, and the additional fact that such instances are most frequent during the cooler seasons of the year and in breast fed, healthy infants points to dentition as the exciting rather than the predisposing cause. In the treatment of the former class of cases the use of remedies known to assist in the process of teething will with advantage be combined with the use of such more particularly indicated by the character of the intestinal lesion. In the latter cases of reflex diarrhœas, if any remedies are found necessary, those for teething "pure and simple" will be found sufficient. Whether a certain degree of looseness of the bowels can be considered normal, or at least beneficial during teething, is a mooted point. From my own observation I am inclined to believe that it is to be regarded as a comparatively harmless, if not beneficial, vent for undue nervous erethism.

The twitchings which often occur in children when a tooth is

about to appear is an instance of a purely reflex phenomenon which usually requires no treatment, but which may usher in that complication of dentition so much dreaded by mothers, convulsions.

The frequent occurrences of convulsions during dentition is sufficient to establish their causal relation to the process. The hypersensitiveness of the normally so sensitive nervous system of children renders it particularly liable to such explosions from trifling causes, such as acute indigestion, fright, etc., but cases do undoubtedly occur where they are purely reflex, the primary and direct result of dentition. Of course as such they are most likely to be met with in those with neuropathic tendencies, or with constitutions weakened by hereditary syphilis, or tuberculosis, or by rachitis, but they are not unknown in the healthy.

That dentition, even normal, as far as the process itself is concerned, may be the occasion of the appearance of lesions of the skin, or of the aggravation of previously existing ones, can hardly fail to have been observed by every one of us. An eczema which we have fondly hoped to have cured because it has disappeared during the interval between the eruption of the several groups of teeth will suddenly reappear as bad as ever, only again to vanish, with or without treatment, after the tooth has pierced the gum. Annoying strophulus and urticaria are very common attendants upon the approach of a tooth to the surface, and generally resist all treatment until the gum has been pierced.

As would naturally be expected, a localized stomatitis, causing but slight symptoms, may be regarded as an invariable accompaniment of the pressure of the advancing tooth. This may, however, become aggravated to such an extent as to result in the formation of superficial ulcers. These, by their sensitiveness, cause the child to refuse to nurse, either from the bottle or from the breast, thus seriously interfering with its general nutrition.

The submaxillary lymphatic glands, when the upper, and the parotid, or upper cervical, when the lower jaw is affected, often become temporarily swollen. This may progress to acute or chronic suppuration, aggravated at each successive eruption of teeth.

The causal relation evidently existing between dentition and bronchitis, complicated frequently by catarrhal pneumonia, is sometimes difficult to demonstrate conclusively; but that here in the respiratory tract, as in the case of the gastro-intestinal tract, there is a condition of hypersensitiveness which renders it especially prone to catarrhal derangements must be recognized.

The earache which so often accompanies teething is readily explicable by the reflex connection between the roots of the teeth and the membrana tympani by means of the otic ganglion. The pain is produced by a congestion and distention of the vessel of the membrane and the accompanying stretching and pressure. Where these symptoms occur without symptoms of local irritation, they must be regarded as purely reflex in character, and the question of lancing the gums will not arise.

Cases of local œdema are at times met with, and may give rise to a wrong diagnosis, and are, therefore, carefully to be distinguished from œdema dependent upon other causes. The œdema of dentition is usually unilateral, although it may also be bilateral. It may be met with in the face, or in the eyelids only, or may attack the hands. Treatment is rarely required, but if it is I have found Apis most frequently useful.

The above are the most important forms in which disturbances produced by the process of dentition are likely to manifest themselves. They are important as giving indications for their prevention and cure on a rational basis. The nutritive and nervous systems are the main points of attack, and these, therefore, should receive our particular attention in the non-medicinal treatment. By carefully watching the progress of growth and development of the child, and adapting its food to the requirements of each individual case, having more regard to the general condition of the child than to its age, we can so fortify its nutrition and supply the elements needed for the growth of the teeth that gastric derangements will not be apt to occur. The fear of these latter is often made the reason for giving insufficient nourishment, and becomes thus an active cause of the production of malnutrition, thus bringing about the very condition it is intended to prevent. A diet, therefore, the most nourishing and least irritating, containing the lime salts in abundance, will be of as much value in preventing as remedies are in curing this form of disturbed dentition.

The hypersensitiveness of the nervous system, and the number of reflex phenomena possibly resulting, should admonish us to keep the child in an environment free from excitement or influences calculated still further to unbalance the nervous equilibrium. It would lead too far should I attempt to enumerate the many ways in which this principle is violated. Constant changes of position, of scene, of attendants, etc., are all calculated to excite and irritate the nerves and should, therefore, be avoided as much as possible, and remedies par-

ticularly adapted to calming irritability should be frequently and persistently employed.

I will not offend your dignity by going over the list of the remedies for disturbed dentition found in every homœopathic work on children's diseases, extracted from every materia medica, with the same well-worn symptoms; but in closing would advise that in all cases of disturbances occurring during the period of dentition, with the remedy apparently called for by the symptoms, either Calcarea carbonica or Calcarea phosphorica be given concurrently, two or three times a day, the former, where the nutritive, the latter, where the nervous, system appears most subject to attack.

DISCUSSION.

Dr. J. W. Thatcher: I do not think there is very much to say on the subject. The indicated remedy always bears fruit, and I am rather disposed to think in the majority of these cases of nervous irritation that there is very frequently some constitutional trouble back of it all and the constitutional remedy brings about a happy result. I do believe that lots and lots of children are made to suffer very much by the pernicious habit of lancing the gums, especially before the tooth is pressing on the outer surface of the gum. I never resort to any measures of that kind, except when the gums are very tense—the membrane of the tooth is there and is very tense and thickened, then simply a little scarifying of the thickened tense skin relieves the horrible sensitiveness of the gum to the benefit and comfort of the child. Of course, an internal remedy is always required.

INTUBATION OF THE LARYNX IN DIPHTHERITIC LARYNGITIS.

J. D. BOILEAU, M. D., PHILADELPHIA.

Intubation of the larynx is an operation for the relief of dyspnœa resulting from stenosis of the larynx due to swelling or the presence of membrane; and consists of the introduction of a tube into the larynx through which the patient may breathe, and which is allowed to remain in place as long as the indications for its introduction continue.

"The first attempt to introduce a tube into the larynx was made by Bouchut, of Paris, in 1858. The tube used by him was a metal

cylinder less than one inch long, narrowed at one end. It was carried forward at the end of a sound and left in the larynx. Attached to it and brought out at the angle of the mouth was a silk cord to secure the tube and finally to aid in its removal. Bouchut published seven cases of intubation in laryngeal diphtheria, in all of which the larynx had tolerated the presence of the tube and the dyspnœa had been relieved. These two points were nearly lost sight of in the heated discussion which followed upon the claim of the author regarding the advantages of "tubage of the glottis" over tracheotomy. The new operation had but few cases and no recoveries to recommend it. The Paris Academy of Medicine appointed a committee, with Trousseau as its chairman, to investigate the merits of the proposed substitute for tracheotomy, and at last accepted its report that it was impracticable."—(W. P. Northup.)

We are indebted to Joseph O'Dwyer, M. D., of New York, for the modern operation of intubation, and the excellent instruments bearing his name for its application. O'Dwyer began his investigations about 1880, his first experiment resulting in a sort of bivalve speculum, attached to a staff. It was introduced closed, and sprang open on the withdrawal of the handle. This was in a measure successful, but not wholly so, as the membrane and swollen tissues protruded through the fenestra, and the dyspnœa which had been relieved would recur. Further experiment on his part resulted in the solid metal tubes of the O'Dwyer intubating set as now used.

The outfit consists of six tubes of varying sizes, adapted to any age from the infant of one year or less up to the adult. These tubes are of metal with heavy walls, their weight aiding in their retention and preventing them from being readily coughed up. They are usually gold-plated, and provided with a hole in the upper extremity to admit of its carrying a silk cord. Each tube is adjusted to fit the larynx of the appropriate age and rest upon the false vocal cords, at the same time allowing the epiglottis to close down upon it during deglutition. The proper tube is selected with the aid of a steel scale provided for the purpose. The mouth gag is designed to engage the molars of the left side; curving around the angle of the mouth the handles rest against the left cheek. Each tube is fitted with an obturator which completely fills its lumen, preventing it from choking while being introduced. The obturator screws on to a handle, and is released from the tube by the action of a sliding bar on the handle. The extractor is a curved forceps, with goose bill blades, which open and

engage themselves in the upper extremity of the lumen of the tube when the handle is pressed.

The operation of intubation of the larynx is extremely simple, yet one requiring some practice and dexterity. It requires but a few seconds to perform it, and when it is properly done is attended with no pain or loss of blood. The instruments having been made aseptic by boiling, the tube of suitable size is selected and the obturator accompanying it screwed on to the handle of the introducer, a silk cord having previously been passed through the hole in the upper end; this is to recover the tube in case that it has been passed into the œsophagus. The patient, who is usually a child, is rolled in a blanket with the arms secured to the sides of the body, and placed on the lap of the assistant, with the head resting on the left shoulder; the gag is placed between the molars of the left side and opened as far as possible. It is well for a second assistant to stand behind the patient and steady the head, at the same time keeping the gag in place with the left hand. The operator holds the introducer in his right hand, with the left index finds the larynx, lifts the epiglottis, and passes the tube along the left index finger into the larynx; at the same time the finger is shifted into the œsophagus to make sure the tube is in proper position; then quickly release the tube from the obturator by pressing forward the slide on the handle. After the patient has taken a few inspirations and cleared the tube by coughing out what little membrane or mucus may have been drawn into it the finger is again passed over the mouth of the tube, and after making sure it is in position it is pressed well down and held there while the cord is slipped away, the gag is removed and the operation is complete. The results are instantaneous and gratifying. The little patient who a moment before was restless, fearful, cyanotic and gasping for breath now breathes easy, and for the time all dangers are passed and the life spared long enough for the remedies to be administered with some hope of producing results.

The indications for the operation are those of obstructive dyspnœa. The breath is superficial, difficult and often attended with a croupy sound. There is restlessness, anxious expression of the face, the lips become livid, the supra-sternal, supra-clavicular, and intercostal spaces become depressed. These symptoms may come on suddenly, rapidly increase in intensity, and call for prompt interference. Intubation will meet the indications in most cases and is to be preferred to tracheotomy. It is less objectionable to the parents, is painless, bloodless, attended with no risk and but little shock. It is quickly

done, and requires no skilled assistant or anæsthetic. The air enters the lungs more nearly in its normal condition, being warmed and moistened in its passage through the nostrils. We have no open wound to become infected, nor any of the complications of tracheotomy, as pneumonia, abscess, fistula, or ulceration. The disadvantages are slight and easily overcome; pieces of membrane may be pushed down before the tube as it enters the larynx, and as the obturator is removed enter the tube and completely shut off the air; the tube must be removed and replaced again as soon as it is cleared. This accident happened me once. While the tube is in position there is some difficulty in swallowing. By placing the child in a favorable position as on the side or with the head low, giving liquid or semi-solid food fed slowly, this trouble can be overcome. The tube should be left in until the disease is under control, usually about five to eight days is the time required, but if removed too soon should be replaced.

Attempts have been made to formulate the percentage of deaths and recoveries, but this is misleading, the mortality being that of the disease with a very serious complication removed, the operation having relieved the condition for which it was intended, and adding no new complications, nothing more from it should be expected.

It must be evident that an early operation is advisable, before the patient becomes worn out by the efforts of breathing, loss of sleep, and heart failure, and cyanosis manifest themselves.

PERSONAL EXPERIENCE WITH ANTITOXIN IN DIPHTHERIA.

F. D. BREWSTER, M. D., SCRANTON.

It is not my intention to try to add anything to the knowledge of the pathology of diphtheria in the present paper, but to confine myself entirely to its treatment.

The diagnosis of diphtheria may present difficulties under certain circumstances, but in the presence of well-defined and virulent epidemics not many mistakes need be made. Under the name diphtheria I include membraneous or true croup, which I believe to be always diphtheria affecting the larynx and air passages.

During the past four years I have treated successfully 279 cases of this disease without a single death. More than four years ago

a bright and only child suffering from diphtheria of the larynx was very near death's door in spite of all that myself and colleague, Dr. Smith, could do for its relief.

Antitoxin was administered, and the patient responded at once and got well. The same week another little patient attacked with the same disease got the dose early and recovered promptly. Since that time I have administered antitoxine to every case of diphtheria as soon as a diagnosis could be made, if I had the opportunity, and with uniform success.

A detailed account of these would fill a book. Some have been more striking than others, and some quite dramatic. Some have been given up to die by their attending physicians, who said they could not live the night through.

These 279 cases have occurred during four or five severe epidemics, and do not include any cases of doubtful diagnosis. How the antitoxic serum cures diphtheria and what its relation is to a homœopathic action I do not know. I should like to know. That it cures, I do know. In a simple tonsillar or faucial case injected early with the proper dose I can say to the patient: "You will be well in three days," and seldom will this prediction fail. And "well" will mean completely well, without a symptom or a complication left. The proper dose is a question for the physician to decide in each case.

For a simple case seen early 1,000 units will suffice, and only one injection will be required. If seen later, or the case be severe, 1,500 or 2,000 units had better be given, and the physician stand ready to repeat the dose. In laryngeal cases do not temporize with less than 2,000.

It has been my custom to use the indicated remedies in conjunction with the serum. This need not prove that the remedies cure and not the serum, for I have known patients to die in spite of the best remedies I could prescribe.

As regards local applications to the throat, I have not used them. Let the throat alone, and the exudation will clear off in 24 to 48 hours.

Strict isolation and room disinfection have been practiced in every case when practicable.

If there are other children in the family who have been exposed, it is my practice always to give the immunizing dose of 500 units providing the parents will consent. Without such consent in a patient already attacked I would resign the case. I have never seen a

person contract diphtheria who had received the immunizing dose within three months, no matter how great the exposure, and I have seen such children playing rough and tumble on the same bed with a patient day after day. The number of immunizing injections used has been upwards of 100, and these children have been very carefully watched by anxious parents and doubting friends, as well as by their physician, to see if any harm resulted from this horse-serum injected under the skin. Beyond a slight erythema of the skin appearing around the point of injection, and disappearing in two or three days without treatment, nothing to disturb health has ever been discovered.

Strict aseptic precautions should be used in handling the serum. I employ an all-metal syringe, and boil it immediately before using, filling it while still warm enough to heat the fluid to about the temperature of the body before injecting. Attached to this is an ordinary fine hypodermic needle frequently renewed to keep it bright and sharp, and with this outfit the injections are not painful. One child received the dose while asleep and without awaking.

A bottle once opened and the contents exposed to the air should be used at once or not at all.

As regards complications and sequelæ, I have rarely seen them in these cases. If the patient is treated early and sufficiently—never. In cases seen later and saved "so as by fire," the usual cardiac weakness, muscular paralysis, and albuminuria may develop. These I have learned to attribute, not to the antitoxine, but to the want of it. I have never seen any ill effects, either direct or remote, that could be traced to this agent.

This, fellow-practitioners, has been my personal experience with antitoxin in diphtheria. If this brief paper seems egotistical and lacking in argument, it will be remembered from the title that it did not promise argument on the subject.

If serum therapy in diphtheria is not homœopathy it is like it in being satisfactory, and we, as progressive physicians, can no more afford to ignore it than we can to omit the use of salines and colon flushings to rid the system of ptomaines when the patient is suffering auto-infection from these poisons. I believe this serum treatment is the best that has been so far devised for diphtheria. If this is true, are we not morally bound to use it in every case? No doubt the usual large percentage would recover under the homœopathic remedies alone. If some should die that antitoxin would have saved, are we not criminally negligent if we fail to use it in time? An-

other, and by no means a minor, argument in favor of its use is the great saving in suffering, time, and expense. I believe that the time required to cure a given case can be reduced to $^1/_4$ the number of days required by any other means. This, of necessity, correspondingly reduces the suffering and expense.

If the lessened fees received should furnish a motive in the mind of any medical man for not using it he is unworthy the name of physician and unfit for association with gentlemen.

DISCUSSION.

Dr. Charles Mohr: It appears to me that this is one of the most convincing papers I have ever heard in the use of the antitoxin treatment for diphtheria. I say apparently convincing, but to me it is not as convincing as it is to Dr. Brewster for several reasons, and we can only get at the real gist of this matter by considering all sides of the question. Now, whenever a paper is written in regard to the serum treatment of diphtheria usually the paper commends the method, and it is only in discussion, if men will speak their minds freely, that offsets are made against the use of this agent, no matter how convincing the paper may be that commends it in the treatment of this disease. Now, personally, I may say that I have never used antitoxin in any case of diphtheria. I have not had as extended an experience as that of Dr. Brewster. I am free to confess that my cases have been comparatively few; some of them have been severe, and they have recovered under the indicated remedy. Now, I contrast my experience of the last three or four years when almost everybody, almost all my medical friends, have lauded antitoxin; it has been my experience when I first began the practice of medicine, and I remember in one epidemic in Philadelphia that my mortality rate was just about 50% and I used nothing but homœopathic treatment, and, at that time, occasionally would employ the chlorinated lime solution as recommended by Dr. Neidhard; but within the last five years, although I have treated diphtheria in the faucial, laryngeal and nasal forms, I have not met with a single misfortune. I have talked with physicians who have used this agent. Many of them, as Dr. Brewster says, have such a great confidence in it that they think a man is criminal who does not use it; but, on the other hand, I have talked with a number of physicians who have used antitoxin and condemn it. Only within the last few months I was talking to one of our Philadelphia doctors. He said he was today giving antitoxin to a case of diphtheria because that was the only means of

saving the patient's life. The consulting physician was so confident that antitoxin would prove remedial that he yielded to the consultant's opinion, and the child died after being given 2,000 units. In that same family there were two other children, and the consultant again said: "This child has not an immunizing dose of the serum; give it the antitoxin at once and give it 1,000 units." When the third child showed evidences of diphtheria, and because one of these cases had died and the other not, the doctor concluded he would go his own way and use simply his homœopathic remedies exclusive of antitoxin and the child got well. There are numbers of such instances in the experience of many physicians. I tell you what is a remarkable fact, and I am saying all this, understand me, because I thoroughly believe there is a remarkable similarity in antitoxin to diphtheria and its conditions—in other words, I believe that we have here a homœopathic agent, if we have anything; but we all know who have studied homœopathy that there is not a single disease in the whole category of diseases in which one remedy, no matter how homœopathic, is the cure-all. Therefore, I contend that in antitoxin we have not an agent that must be given because it is more curative than any other. Now, the antitoxin treatment, as you all know, originated in Germany and thence it spread all over the world. I have been very much interested in reading the statistics in certain localities. I read a very convincing article from the other side of this continent some months ago, in which it was stated that in the very large centres of Europe, in Russia, in Germany, in France, in England, Scotland, etc., where the antitoxin treatment had been used for ten successive years, the mortality rate of diphtheria, so far as statistics could be gathered from hospitals, from private practice, etc., amounted, in the last year, 1899, I think it was to forty-three per cent. That was the mortality rate of diphtheria during the year, notwithstanding the use of antitoxin. And another curious fact in respect of these statistics was this, that while no serum treatment had been employed in other contagious or infectious diseases, such as scarlet fever, the mortality rate in scarlet fever, as compared with other years and decades, was very much less than the diphtheria mortality. That proved to me conclusively that we have not a specific for diphtheria in antitoxin. I take that position. I think we should investigate this question and I think we ought to hear just such papers as Dr. Brewster has read; but I think we ought to hear the other side of the story so we know just where we are.

There is one curious fact Dr. Brewster admits—he gives the indicated remedy along with his serum treatment. Old school doctors do the same thing. The homœopath who uses antitoxin uses his Belladonna, his Mercurius, Lachesis and Lycopodium. Take the old school man who uses his serum, he uses his Iron and Mercury—not so much now; but when he reports a series of cases in which he has success, he always reports the success is due to antitoxin and gives no credit to the other remedies which have been employed. I do not think that is the proper position. If I had the confidence in the serum treatment of antitoxin that Dr. Brewster has I would use antitoxin every time and nothing else, and then I would know what value to place upon it.

Dr. J. H. Mansfield: I have treated some two or three hundred cases in Germantown. I have tried the antitoxin serum with and without the remedies and have not lost a case of diphtheria since commencing the use of that treatment. I think it is a great mistake to wait too long before we use it. I use it as soon as I make a diagnosis. I give one thousand units. I do not stop there. Every day I repeat one thousand units in bad cases. I have given as much as sixteen thousand units in five days. With a case of valvular disease of the heart there was no effect whatever as a depressant, but rather a stimulant to the heart's action. If it is given frequently in the most violent cases they will get well.

Dr. Charles Mohr: I know a physician in a neighboring town of Philadelphia who has used antitoxin almost to the exclusion of everything else, and what is his experience? He says that whenever he uses more than five hundred units he has had bad results. When he confines himself to five hundred units he has had good results. He never uses more than five hundred units and has better success than when he uses more.

Dr. J. H. Mansfield: Dr. Mohr said he thought it was more nearly a homœopathic remedy than otherwise. I believe it is more on Hahnemann's theory of drug cure. I think the serum treatment comes close to the Psorinum treatment.

Dr. D. P. Maddux: We have an agent here endorsed by competent, reliable men. Whether we are not as yet in a position to say that it is the only agent necessary, yet it seems to me that now a man stultifies himself if he is not willing to admit it is one of the most potent, and, many of us think, the most potent agent in the treatment of this trouble. We say that Mercury or Belladonna or any of the other agents are valuable remedies in the treatment of diphtheria;

but here we have a valuable remedy which Dr. Mohr has absolutely discarded, which he has never used, and as far as we know and have heard discussed adverse criticism has come from those who have never used it.

Dr. Charles Mohr: I did not say it might not prove a useful agent, but I want it to find its proper place in the treatment of diphtheria as compared with other agents. When I say I have never used it I tell of my individual experience. I am not condemning antitoxin. I am alluding to those physicians who have used it and condemned it.

Dr. J. H. Sandel: This discussion on antitoxin is unique. Men who do not use it are the ones who make the most noise against it and tell of the experience of those who use it without any good result. Personally my own experience goes as far—what I will say—as any statistics I can get, read or hear. Many of its opponents say: "I do not use antitoxin or never did, never have in the past and do not think I will in the future. I would not use antitoxin; I would treat homœopathically."

My experience has not been such in the past that I have not been able to treat diphtheria without antitoxin. In the two last years where I have made, I might say, the occasional use of antitoxin, I only lost two cases of diphtheria, and if I had used my best judgment in the treatment of those cases I feel perfectly satisfied they would be living; two nice girls, one ten years and one fourteen years old, would be spared to their friends. In one of these cases their friends said they would not have the poison injected into the girl and the case died. The other was a girl fourteen years of age; I did not use antitoxin. I commenced the case in the very beginning and influenced by some of my brother physicians who pooh-poohed the antitoxin treatment I once more did my best to study my case three or four times a day and gave it abundant attention, but the child died in about twelve days.

Dr. J. W. Coolidge: I know in Scranton we can all corroborate what Dr. Brewster says. Every man who uses antitoxin has had the satisfaction of curing all cases; it works to perfection there. Some of my friends outside tell me it does not work well. I believe we have an explanation of the character of the disease. We have toxine infection in one case and bacillus in another.

Dr. J. W. Thatcher: I have never used antitoxin. I have met a good many doctors who have, both old school and homœopathic friends. A great many of them tell the same story that we have

heard, and a great many allopathic doctors, as well as homœopathic physicians, condemn the treatment. I have always depended on the homœopathic remedy, and I have had splendid success. I do not say that I have not lost cases; I have. But it seems to me strange, in this age of provings of drugs, that the great amount of medication that these people have been subjected to at the hands of their physicians that they do not note some characteristics, indications for the drug, or, in other words, some provings. It has occurred to me that it is a very strange affair—I mean that there should be a regular proving of antitoxin as other things have been proved.

I would like to ask the question of those who have used it, and of the doctor here, if he has observed any symptomatic indications or any condition aside from the simple fact of his diagnosis wherein we could depend upon employing that drug symptomatically. It seems very strange that with the amount of medication (from what I infer, they crowd this treatment just as far as they dare), they should develop some symptoms while curing the case. There must be some aggravation of symptoms. If it is so potent to cure, it is just as potent to produce symptoms, and we recognize the fact that only on healthy subjects can we get provings of anything. If it has been so, I should like to hear an expression on that one particular point. Then we will know where to place it.

Dr. T. S. Dunning: In the discussion of scarlatina I was led to answer a remark made as though it is a settled thing that antitoxin is acknowledged by the best observers to be a cure for diphtheria. It was on account of that that I was led to speak as I did. I am not opposed to the use of any measure which will help my cases. I believe in the homœopathic law of cure, as far as I am able to apply it. I recognize sometimes the limitations of the law; I recognize still more my lack of knowledge of remedies and my ability in the application of the law to my cases.

In regard to antitoxin, I want to know the truth. If it presents something, if it is going to make any record like that which Dr. Brewster has given, it is beyond anything that I have ever heard or seen in any paper, and I am simply delighted with his success; I want to learn how to do it, too. If there is this difference in results in different men, there must be a difference in the disease which they treat—which I think there is—or there must be a difference in the remedy which they use. Now, you can scarcely today take up any of these trade journals issued by this house or by that house that do not run down every other house, and they say the reason they don't

get results is because Mr. Jones's preparation is not the correct one. On what antitoxin can we depend? If there is any antitoxin that will give Dr. Brewster's results I want to know it. I often wondered where the cases of diphtheria in Philadelphia are anyhow. I do not have any of the hospital work of that character, but I do occasionally see a severe case of diphtheria, and I wondered where these hundreds and thousands of cases reported are. I find out now that they are in Germantown, and Dr. Mansfield has his large proportion. I do not know what means of diagnosis they have. I believe there is a difference in diagnosis. We have no such means, and we try to make a distinction between the severe cases of tonsillitis which have a membraneous deposit upon the throat, but which do not present the characteristic indications of diphtheria. As for those ordinary cases I speak of, what is the use of injecting in such cases as that when you know you have remedies that will cure; but if they are extreme cases of true diphtheria that are beyond ordinary treatment (I have come across such cases and I would have given my life to have saved some of them; I had one such case in my own family), and if antitoxin, whether it is made of horse blood or not, cures cases of diphtheria, I will fly to it.

Dr. J. H. Mansfield: I do not like the preparation that the Philadelphia Board of Health gives you; it is slow and uncertain. I am not particularly pleased with Parke, Davis & Co.'s preparation, and hold on to Mulford's. I think with every case in which I used Mulford's preparation I got prompt and good results. If Dr. Dunning will watch the report of cases—we always have them in Philadelphia, every month of the year we have cases—he will be able to see for himself. We have smallpox in Germantown; today you will find a record in the Philadelphia papers; we have brought cases in every month of the year in Germantown and Nicetown. There may be a difference in the size of a man's practice. If he only makes fifteen visits a day he will see no cases of diphtheria, but if he makes sixty or seventy visits he will run across them. If you have a large practice you will see more cases. My own practice extends from Chestnut Hill clean down to Rising Sun. I think, without exception, my cases have been cured with the aid of the best selected remedy I could use and the best talent selected from Philadelphia.

Dr. Charles Mohr: Have you not lost a case?

Dr. J. H. Mansfield: No, sir. In one case I gave an unfavorable diagnosis. "If you wish, I will try antitoxin." I do not know whether parents are favorable to its use until I find out by present-

ing the case in that way. If a patient says: "I do not want it," I resign the case. If I treat it, I will treat it with antitoxin. I believe it is homœopathic. I believe you have the symptomatology there just the same as in Kali bichromicum. I do not think that Belladonna is worth anything in a case of pure diphtheria.

A MEMBER: What is your indication for its use?

DR. J. H. MANSFIELD: A patch which cannot be removed without causing sloughing of the tonsil.

A MEMBER: No other indication?

DR. J. H. MANSFIELD: That is the indication. You get your last stage when you get a tendency to sloughing of the throat.

A MEMBER: Do you give remedies?

DR. J. H. MANSFIELD: Sometimes I have done so, but I do not think they are of much effect. I think in the laryngeal type you cannot depend on Kali bichromicum, and I have used it away down to the first decimal potency. I have had my solution so yellow that it would pretty nearly dye your finger, but it will not cure. I have not lost a case of diphtheria, laryngeal or pharyngeal, where I have used antitoxin at the first visit.

DR. CHARLES MOHR: I want to say one word in reference to Belladonna. It is an agent with which I have succeeded well in those cases that go on rapidly with inflammatory symptoms before you have any pronounced blood poisoning. If you would use Belladonna on the indications you do get as thoroughly as you use antitoxin, you would modify every case to such an extent that a fatal termination would hardly occur. When I treat cases of that sort, and, say, I do this with Belladonna, and my friend who believes in antitoxin says: "This is not diphtheria," how does he know? I have cured laryngeal diphtheria with Kali bichromicum and used nothing else.

Another point with regard to laryngeal diphtheria, a medicine very seldom used which has proved successful in my hands is Hepar. I remember two children, a boy and a girl, had faucial diphtheria first and it then invaded the larynx; the girl almost suffocated. I had Dr. A. R. Thomas in consultation. I gave Hepar and stuck to that remedy. That girl recovered from her laryngeal symptoms, although she had paralysis for six months. If that case had gone to Dr. Mansfield and he had given antitoxin he would say that it would have died under any other treatment. I have been through this diphtheria discussion ever since I have been in the practice of medicine. I remember in our county society when a discussion was held on this disease, and it was during the prevalence of an epidemic throughout

Pennsylvania, a homœopathic doctor from the interior of the State claimed he had one hundred cases of diphtheria, and every case recovered. He did not believe in potentized drugs. Did not see any relevancy between Ignatia and Diphtheria. I said to that doctor: "Why you didn't treat diphtheria; your cases were not diphtheria. If you had had diphtheria one-half would have died." But they did not die. Was he mistaken or was he not mistaken? I do not think that Dr. Dunning for a moment meant to make any reflection on Dr. Mansfield's large number of cases. Dr. Dunning said that Dr. Mansfield's statement that he had over two hundred cases in five years was probably incorrect, and that some of them more likely were diphtheria, but a great many of them were not diphtheria. Now, what I want to get at is this—I am only after the truth. I want to know whether we can depend on antitoxin to the exclusion of everything else in the way of medicinal treatment when you have diagnosed diphtheria, and it cannot possibly be anything else but diphtheria, coming to the point that Dr. Dunning alluded to in regard to the various preparations of the serum product called "antitoxin." We have a municipal hospital in Philadelphia. Dr. Welch is in charge of it. Dr. Welch began the use of antitoxin at the very beginning of its introduction and he reports year after year to the municipal authorities that his mortality rate in diphtheria is 35%, 40%, etc., and it was said to Dr. Welch you are not using the right serum. Then he tried Parke, Davis & Co.'s and he tried Mulford's and he reported the same result.

A Voice: He did not use enough of it.

Dr. Charles Mohr: You say he did not use enough of it. Now, our city authorities established a bacteriological laboratory and they produce a serum that men in Philadelphia would swear by—they say if you use that you will get good results. For one whole year Dr. Welch was compelled to use that particular serum. Nine-tenths of the allopathic and homœopathic physicians in Philadelphia said: "That is the serum." Dr. Welch used it a whole year, and his mortality rate was just as before. Now, where are we?

Dr. F. D. Brewster: I have no desire to take up any more time. I am very glad the discussion has taken this form. I have nothing further to offer than my personal experience. I came here to find out as much as possible. I can answer some questions which have been asked. The one I think I have in mind was in regard to the kind of antitoxin; the variety I have used, with one exception, has been Mulford's. In one case I used another serum which I do not think acted

so promptly. With regard to diagnosis, I have been careful. I admit I injected it in some cases in which I was in doubt as to whether they had diphtheria. I injected them to be safe, and the cases ran along of themselves, a slow follicular tonsillitis. I recognized it. I believe antitoxin is of use for diagnostic purposes. If you have a case of true diphtheria you will see it respond so promptly that you will know that it is diphtheria. I believe it is the most valuable diagnostic means that we have. There is no doubt that if antitoxin is given in season, and in sufficient dose, the case will be well in three days.

By a Member: What is a sufficient dose?

Dr. Brewster: That is a question for the individual.

A Member: What has been your experience?

Dr. Brewster: I have never given more than one thousand units.

A Member: Even when you have a late case, when your blood poisoning has set in, say, the fifth or sixth day?

Dr. C. C. Rinehart: I never use less than two thousand units, and even prefer three.

SCARLATINA.

M. J. HOLBEN, M. D., SLATINGTON.

This well-known disease is generally classified among diseases of children, but adults are often attacked. And it is defined as an infectious and contagious febrile affection, characterized by a scarlet efflorescence of the skin and mucous membrane of the fauces and tonsils; the period of incubation is from a few hours to some two weeks, usually about six days; the scarlet rash usually makes its appearance on the second or third day, ending in desquamation about the sixth day. Scarlatina has long been confounded with measles. In 1556 a work published by Ingrassias, although not describing it as a distinct affection, calls it a peculiar disease. Dr. Withering, a British physician, has the credit of being the first who clearly defined the difference between the two diseases of scarlatina and measles, and established the claim of scarlatina to its present rank. There are three distinct varieties of this disorder—scarlatina simplex, in which the skin is only affected; anginoid, in which both skin and throat are implicated; malignant, in which the main force of the disease seems to be expended on the throat. As preliminary symptoms,

we have languor, weariness, pain in the back and limbs, rigor with shiverings, seldom a chill, frequently vomiting and spasms; there is a rapid rise in temperature, often reaching 105° F. during the first days; the pulse is very high, hot dry skin, flushed face, tongue coated white shows projecting papillæ on the surface, red at the tip and edges, after losing its original coating looks very dark, imparting to it a strawberry appearance. In severe cases of headache, restlessness, delirium, stupor, coma or even convulsions we soon observe red points which coalesce rapidly and form broad patches in a few hours, or scarlet blush more intense in the flexure of the joints, fauces appear red and swollen, mouth of a red diffused appearance. One attack of scarlatina generally gives immunity to a second attack. Prof. Raue says the white spot so made grows red again from the periphery to the centre; unlike that in measles, which spreads from the centre to the periphery. Desquamation begins with the decline of the eruption or rash, usually completed by the end of the second week. As unfavorable symptoms or signs, we have a late appearance of the rash, deficiency or sudden retrocession of the eruption, continued delirium or profound coma, a livid or purplish color of the rash and fauces, gangrenous sloughs or ulcers, bloody discharges from the bowels, intercurrent diarrhœa or dysentery, bleeding from the gums, mouth or throat, œdema of the lungs, scanty urine with an abundance of albumen.

As sequelæ we have abscesses which usually form in the vicinity of the parotid glands, from which the patient often succumbs or dies of hectic fever. Ozæna or otorrhœa is liable to occur in scrofulous subjects. The most serious of all sequelæ is dropsy, generally in the form of anasarca, attributed to an abnormal condition of the kidneys caused by their effort to throw off the poison from the system, although it may take the form of nephritis with its grave concomitant symptoms, of which the majority of cases recover; the kidneys are rarely permanently diseased or injured. In treating a case of scarlatina, I have found it very important to place the patient in a large, clean, well-ventilated upper room, if possible isolated and confined to bed, temperature of room about sixty degrees Fahrenheit, and well disinfected. The patient should be covered with linen sheet and blankets, as thick coverings will prevent access of air to the skin, consequently interferes with its functions. The diet should be of the simplest—fresh fruit, gruel, milk. Ice cut in small pieces may be given in the mouth, barley or toast water, as drinking increases the action of the kidneys as the fever consumes a large amount of

moisture. If a high fever or temperature, sponge patient with tepid water. Utmost caution must be taken to prevent a chill. Carbolized vaseline or cocoa butter prevents itching due to the eruption or rash.

Remedies.

Prof. Raue recommends Belladonna as a prophylaxis.

Prof. Hering, Sulphur if the skin looks like a boiled lobster.

Aconite.—In the beginning to moderate the fever, with a dry hot skin, restlessness; full hard pulse.

Bryonia alba.—To develop the eruption if delayed or suddenly disappears, in pleuritis or meningitis.

Rhus toxicodendron—Typhoid symptoms, if the rash is dark colored and itches.

Apis, Arsenicum, Hellebore, Apocynum, Terebinthina, Cantharis, post-scarlatinal dropsy.

Mercurius jodatus ruber, Calcarea carbonica, Graphites, Sulphur, Silicea for glandular swelling and suppuration.

Mercurius sublimatus corrosivus, Pulsatilla, Silicea, Hepar, Sulphur for otitis and otorrhœa.

DISCUSSION.

Dr. A. P. Bowie: The description of the disease and its treatment is what we all know and has been given very correctly, but there is one peculiarity about scarlet fever that I have noticed of late years, and that is that the form of the disease has changed. I do not recollect having treated a case of malignant scarlatina for a great many years. In the early part of my practice I had a good many cases of malignant scarlatina and I dreaded the disease very much. But in the past ten or fifteen years I have not seen a case. The form of the disease has certainly changed in the region in which I practice, and it is no more the dreaded disease I used to see. It is more characteristic of simple scarlatina than to the older classification. One of the most important remedies in scarlet fever in my experience has been Sulphur. Of course, Belladonna and Rhus toxicodendron and such remedies are useful, but I generally give Sulphur in scarlet fever in most every case, not because it is a specific, but because I think it is an indicated remedy in a great many cases and it reduces the sequelæ to a minimum.

Dr. M. J. Holben: I think a great many scarlatina cases of the present day are called diphtheria by physicians. I think that explains the infrequency of the malignant form.

Dr. J. W. Thatcher: I must acknowledge that I have been very much puzzled over some cases which you can only diagnose scarlet fever by exclusion. About this time one year ago I was called to see a boy who was literally covered from head to foot with red, typical eruption, disappearing upon pressure. There was one conclusion to be drawn, and that was in favor of scarlatina, but there was not another solitary symptom about the boy; he had no headache, no sore throat and just as full of the Old Nick as he could be, and kept them busy all day. They kept him in bed. He had some feverish symptoms and was one of the worst cases for desquamating that I ever met. He simply peeled off from the crown of his head to the toes; the epidermis came off his feet in almost a solid mass and from his hands in the same way, and yet the boy was not so to say sick for any time. We kept him in bed for three weeks. He had no head symptoms. He could eat and drink and cut up, and did not see any reason why he should be kept in bed or why he should not go to school. I did not report the case, and after the desquamation came on I felt more uncomfortable, for it was a family that was quite prominent, and a good many visitors came to and went from the house, and they were very important to the church; and the people could not understand why the members of the family kept themselves aloof from their friends, and put all in a very awkward predicament, yet it was too late to report the case. He made a beautiful recovery and every care was taken of him. It shows how you can be misled. However, I gave him Sulphur, and he made a beautiful recovery.

Dr. G. J. Berlinghof: The majority of these cases that are looked upon as malignant scarlatina are cases of diphtheria. In my early practice I examined the throat very thoroughly where there was exudate upon the tonsils, and looked upon it as an aggravated case of scarlatina, particularly where there was intense swelling, especially of the cervical glands; but in recent years I have looked upon these cases not as malignant scarlatina, but as a disease of a diphtheritic nature. I have not looked upon, but investigated. We have had a great deal of diphtheria in Scranton in the past two years, and I have found the Klebs-Lœffler bacillus present in the majority of cases, and when the membrane was closely watched extension to the pharynx and larynx occurred, and in many cases a diphtheritic laryngitis developed; and, furthermore, to carry me out in my diagnosis I can verify the efficacy of antitoxin in these cases. I have used it in all of them and found the symptoms responded beautifully. Of

course, in connection with antitoxin, I never failed to use some mercurcurial preparation.

Dr. T. S. Dunning: I recall a case referred to by Dr. Thatcher in which there was a very marked rash, and the throat symptoms were so indefinite that it was only by the use of authority that the child was kept in the room and in bed. The family could hardly understand why it was necessary to do so. In all these doubtful cases I believe it is proper to observe isolation and take the same measures as if you are treating a case of scarlet fever, and yet I feel a hesitation in reporting to the board of health those uncertain cases if they are devoid of pathognomonic conditions of scarlet fever—one which I treated had no particular tongue or characteristic throat symptoms, but the rash was diffuse and the blush and spots here and there. There was no scaling or desquamation at the time we usually look for it, but in about two weeks the desquamation was almost universal. I am well satisfied that if it was not scarlet fever it was next cousin to it. There were no other cases in the house, and in spite of my attempts at isolation there was more or less passing from the room where the other children were. But there were no other cases developed, so I am a little doubtful as to the certain character of that case, knowing, as we do, the excessive contagiousness of scarlet fever. It was, however, in the summer time, when the air was passing through the house, and I think there is much less danger at that time. These cases are always doubtful, and I feel uncertain as to whether it is our duty to report them to the board of health. I think we are justified in taking proper precautions, and in giving the family the benefit of the doubt. They do hate to put placards on the house.

Dr. J. W. Thatcher: What cures the doctor's cases, antitoxin or the homœopathically indicated remedy?

Dr. G. J. Berlinghof: My death rate is sufficient evidence of the efficacy of antitoxin. I know that cases looked upon as diphtheritic complications are most usually lost, especially where they avoid the well-known antitoxin. I have used antitoxin in diphtheria in something like 130 cases.

Dr. J. W. Thatcher: Then I would like to ask Dr. Berlinghof why he does not absolutely depend on antitoxin and leave the homœopathic remedy out? If the antitoxin is homœopathically explained, why does he not leave off the homœopathic remedy? That is what we want—a proving of antitoxin. It is an empirical remedy. There

is no true guide to antitoxin; it is an empirical remedy used by the old school, and, I am sorry to say, by our own school.

Dr. G. J. Berlinghof: Within the last five or ten years the fact that the mortality of diphtheria has been wonderfully diminished is recognized by the best physicians of both schools; statistics go to show it, and I am satisfied that the time is coming when a physician will be charged with criminal negligence if he refuses to use antitoxin in cases. That is the experience of many men and close observers. While I do not always do so, I must say I use the homœopathic remedy with it, but my mortality is not any lower from that fact. However, I am satisfied that the antitoxin is more efficacious where the Klebs-Lœffler bacillus is present. The effect is marked within twenty-four hours.

Dr. M. J. Holben: In scarlatina I have always put my belief in the homœopathically indicated remedy. A week ago I had a case of scarlatina—with perfect symptoms of Belladonna—some call it the Sydenham variety, the very picture of Belladonna. I gave Belladonna, and it worked splendidly. Last winter I had a case of scarlatina exactly as I described, a case that looked like a boiled lobster. I gave him nothing but Sulphur. I think antitoxin is a very good remedy.

Dr. T. S. Dunning: The discussion is not with reference to antitoxin, and not with reference to diphtheria, and the doctor says that antitoxin is successful. There are a great many observers who have not been able to make the statement he has made. As to statistics, I do not think that the statistics given, when referred to diphtheria, amount to anything. The rules of the board of health insist that all cases which are at all doubtful shall be classed as "diphtheria." In carrying out that obligation I am not accustomed to class as diphtheria those cases which are doubtful. There is a definite term, diphtheria also, sore throat or herpetic tonsillitis, but many of the slight, apparently insignificant cases are true diphtheria. I would say that these diagnoses are lawfully made, but where there is a doubt give the benefit of the doubt to the family and do not report such cases as diphtheria. If we had taken a record ten years ago and classed all these cases diphtheria as we are expected to do today, taking the average of the homœopathically treated cases, it would show much more favorable statistics than the reported cures by antitoxin. And many of the very best observers, not only in this country but in Europe, are hooting at the idea of speaking of antitoxin as a specific for diphtheria. So I think we should not consider the

matter as at all settled. Antitoxin may be a homœopathic remedy. For my own part I would expect a little from experience. I have not had any success with antitoxin at all. I believe if antitoxin is at all the valuable remedy it is said to be, it ought to act in cases that are severe, even when approaching death. It ought to act, as in the case of the homœopathic remedy, when the patient is almost moribund. I have seen the properly indicated remedy bring a case up from death's door when I have been watching the child for a sign of life, and I have seen that case get well under the indicated remedy alone. If antitoxin is a specific it ought to act on these cases. I have no hope at all when the cases are far advanced that antitoxin will be of benefit. Some time ago Dr. Haines read a paper before the Germantown Club in which he asked the question as to whether antitoxin was valuable or not. He says: "As for my own experience, it is simply negative. I have never had any success at all in a single case where I have used it or had it used. They all died."

PRESIDENT: I think that is positive.

DR. T. S. DUNNING: He said he had never succeeded in curing. Of course, the presumption is that Dr. Haines did not use it until it was far advanced. If I had any reason to expect my homœopathic remedy would take hold, and consider the case was hopeful, I would not use antitoxin.

Now, then, with regard to positive testimony, I have made it my business to talk with Dr. Welch on two or three occasions—Dr. Welch, of the Philadelphia Municipal Hospital, a man who made it his business to watch these cases for two or three years, and I think I spoke to him within a year. Dr. Welch told me candidly. I asked him, "What is the difference in your mortality rate? What is your success in the Municipal Hospital in the treatment of diphtheria since you have been using antitoxin?" "Well, I cannot say that our success is any better than it used to be." Now he has told me that on more than one occasion. He says: "We have to use it, but I cannot say that our success is any better than it used to be." I was not prepared for this discussion, or I should have brought some other authorities, and would have looked the subject up and taken the other side from that on which the doctor has spoken.

RACHITIS.

D. S. KISTLER, M. D., WILKESBARRE.

When we are called to see a patient, a child anywhere between three months or four years, rarely older, presenting an oversized head with an undersized face, large open fontanelles, prominent temporal veins, parchment-like sensation to the touch along the cranial sutures, prominent ribs and sternum, the so-called chicken breast, enlarged knob-like shape to the epiphyses of the long bones, with a probable knock-kneed condition of the legs or outer curvature of the tibia and fibula, with general emaciation, we have no difficulty in concluding that these are the physical evidences, the objective symptoms rachitis cause.

Although rickets is a very common disease among children, the cause of which has given rise to considerable discussion, there yet remains a good deal of uncertainly on the subject.

The relation between congenital syphilis and rickets has of late gained quite a number of adherents. That we frequently can find a history of parental syphilis in rickets can not be disputed, or rather disproved. While again in many more cases there is absolutely no syphilitic history in either parent.

The health of the mother during uterine gestation is considered an etiological factor, rapid child-bearing, with a general impairment of nutrition, anæmia, and health below par, may favor this tendency in the child. However, the causes of this disease arise by far, in the greater number of cases, in the child after birth. Anything which tends to cause an impairment of general nutrition favors this disease. Thus we mention improper diet as of first importance.

That the majority of cases occur in artificially fed children we all agree. A child fed on condensed milk for a continued length of time is likely to develop evidences of this disease. Again, improper clothing, poorly ventilated living and sleeping apartments furnish the exciting cause for a number of those cases. Lack of sunlight, good food and ventilation certainly produce a condition of malnutrition that easily makes its little victim a prey to this disease, and as these conditions are more apt to be found in larger cities and towns it of course follows that most of our rachitic patients are found in the cities.

Diagnosis.—The word picture of rachitis drawn in the beginning of this paper shows the ripened fruit of this disease, and is often beyond remedial help at this stage. It behooves us therefore to institute treatment at a much earlier day, when we can be the means of allaying the on-coming disease before it has produced these characteristic pathological changes in the bones and cartilages. Let me again presume a case. We are called to see a child and find these symptoms: The child cries on being handled, the muscles seem sore as well as the bones, the child may even dread to be touched. The child is cross and irritable.

The mother tells you of the profuse sweating around the head and neck, says the child "wets the pillow around its head." If you find it sleeping you will see prominent veins over its head. The temperature will be above normal, and if scrofulous will kick off the covers. If syphilitic more likely to allow warmth. This is a non-characteristic group of symptoms which we do well to closely observe, and if in addition we find a tendency towards flabbiness of muscles, enlarged ends of bones or enlarged spleen, we know what we have to deal with.

Remember it is not the immediate condition that only concerns us. We must look ahead, and anticipate by prevention those many later changes that are apt to follow. Have your patient sleep on firm bedding; the regulation pillow for the baby to sleep on is very bad. Watch for spinal curvatures.

Treatment.—The diet must be changed. This feature needs careful attention. To leave verbal instructions is not at all satisfactory, for we must remember where we generally find this disease. So we do well by taking time to give full, written instructions to the mother as regards the kind of food she shall give, the method of its preparation, its quantity, and frequency of feeding, and if over seven months old change those written instructions occasionally. A good, wholesome cow's milk that is sterilized heads the list, and it is an easy matter to raise the percentage of fat by adding sweet cream.

Cod liver oil and pure olive oil have great merit; I prefer the latter for various reasons. In older children sucking of meat bones, gravies, and plenty of butter are advisable.

Remedies.—If we find our patient having an enlarged spleen that is marked, which is often an early fact, with an accompanying enlarged liver, we get a two-fold benefit from giving Mercury. 1st, If syphilitic, the case will be much benefited. 2d, If the case improves, and the hypertrophy markedly subsides, it reveals to us the

cause of *this* child's disease, and enables us to do something for the future members of said family.

Sponge baths with alcohol around the head, face, neck and shoulders lessen the tendency to sweating so profusely around the head and neck, and in this way tend to prevent those annoying catarrhal colds in the head and bronchial tubes. Sponging the body with a sea salt solution of tepid water, temperature about 80° Fahr., at bed time has a very nice quieting and soothing effect, often giving our little restless patient a whole night's comfortable sleep.

Calcarea phosphorica given for a continued length of time has been more generally helpful in rachitic children than any other remedy we possess, and this because it offers us a more generally characteristic symptomatology of this disease than do our other remedies.

This patient is much emaciated, has a retracted abdomen, greenish, slimy stools, craves salt meats, has a great deal of gastric trouble, is cross and irritable, sweats freely around head, both fontanelles open, can not support its head, neck so emaciated, mental development slow, and the general soreness seems to be much aggravated on a damp day.

Silicea.—The head is larger than normal. The anterior fontanelle especially is open. The body is small and emaciated, except the stomach which is distended. There is a profuse perspiration around the head, and in older patients of the feet, of an offensive odor. The child is slow learning to walk owing to a poorly developed osseous and muscular system. The ends of long bones are very sensitive, and in advanced cases inflamed and even necrosed. This patient is relieved from being bundled up.

Sulphur.—Here we find, like Silicea, an over-large head, open fontanelles, profuse sweat, small body. But this remedy has a marked tendency to eruptions, boils and crusta lactea. The child is ravenously hungry, wants to eat all the time. The child is much emaciated, the skin shrivelled, of a dull yellow color. The face wrinkled like that of a little old man. This child dreads its baths, and seems better in the open air. There is likely to be an offensive odor if there is any eruption or discharge.

Other remedies, Baryta carbonica, Phosphoric acid, Theridion and Ferrum phosphoricum, Calcarea carbonica. The fair, fat and chubby patient in this disease, if we find him at all, will be in the early development of this affection. Then we will find, besides, the free sweating around the head. The wetting of the pillow around the

head, as our books have it. This sweat has a sour odor, not the tendency to offensiveness as in Silicea. The anterior fontanelle is wide open. The dentition delayed. The abdomen distended very prominently (while in Calcarea phosphorica it is retracted).

The child frequently vomits its milk and passes it in form of small coagula in the stools. There is a general soreness of the muscles, glands and bones. The child craves eggs. The disposition is a cross and irritable one. Rachitis in a child may have a group of symptoms which are most similar to Baryta carbonica, Psorinum, Phosphoric acid or any number of remedies, and if such be the case give them, but fortunate is the child who is under the care of a physician who here recognizes both the great importance of preventive treatment as well as the great importance of the curative value of symptoms.

INTESTINAL IRRIGATION IN INFANTILE DIARRHŒA.

JOHN L. REDMAN, M. D., PHILADELPHIA.

In cholera infantum, entero-colitis, dysentery, and, in fact, all infantile diarrhœas which are dependent upon a primary poisoning within the gastro-intestinal tract, our immediate duty is to counteract it as soon as possible, and this is best done by its removal through intestinal irrigation.

By taking a lesson from nature, and in the light of modern therapeutics, this is the most natural of all treatments now at hand.

It must be done thoroughly, systematically and understandingly to be of any advantage; and is of little avail unless properly carried out; therefore, some reference to the details may not be out of place. Irrigation is useful in all conditions to cleanse the larger bowel and rectum of mucus, fecal matter, undigested food and the products of decomposition and fermentation, and as a means of local medication, and many times becomes imperative, as in cholera infantum when there is not time to wait for the action of a cathartic or the indicated remedy. Our chief indications, therefore, are, (*a*) to empty stomach and intestines; (*b*) to supply body with fluid lost by vomiting and purging; (*c*) to counteract the effects of the poison on heart and nervous system; (*d*) to reduce temperature, and (*e*) to apply local medication.

The apparatus is an ordinary fountain syringe, 5 to 6 feet of rubber tubing, a large size (male) catheter, 18 or 20 American scale, or infants' rectal irrigating tube 20 inches long, with opening at the end as well as eyes laterally on sides near extremity. It is also wise to have a glass joint in the rubber tubing, so that it can easily be seen if fluid is flowing properly.

The irrigating apparatus being ready, the child is placed on its left side, with the hips a little higher than the body, and if an infant, preferably across lap of the mother or nurse. It should be placed on a rubber sheet, so arranged to form a trough emptying into a large basin or tub. With the clothing up to the hips, the bag 4 to 5 feet above the body, the catheter well oiled, the water is allowed to flow just as the catheter is inserted within the rectum. As it flows the catheter is gradually pushed upwards. The water distending the intestines in advance generally makes the introduction easy. If an attempt is made to introduce the catheter before allowing the water to flow it almost invariably doubles upon itself. It is the peculiar curve and great length of the sigmoid flexure that makes the introduction of water difficult, and unless the tube is passed well into the colon the irrigation is not likely to extend much beyond the sigmoid flexure.

The return flow is passed alongside of the catheter, often with considerable force, and the irrigation should be continued until the return flow is perfectly clean and free from all mucus or fæcal matter. Gentle kneading of the abdomen should be continued during the irrigation, particularly during early part, to facilitate passage of water into the upper colon. Early expulsive efforts on the part of the child are lessened by occasionally compressing the tube and checking the flow of fluid, or by pressing together the buttocks. Enough can always be retained within the larger bowel to moderately distend it. The flow should always be slow, so the inflamed and infiltrated gut can adapt itself to the increased tension. It is only an abnormal intestine, dilated in places, or bound down by previous adhesions, or abnormally sensitive, that resents the flow by spastic contractions or by pain or vomiting.

The first irrigation should always be done by the physician, who will thus instruct the nurse to follow his individual methods. He will also be more able to discover any abnormal peculiarities, and by being more expert the baby will not be so startled by the procedures. At the end of irrigation the rubber tube is detached and remaining water is allowed to flow through the catheter. It is not necessary

to retain the fluid, or even attempt it. Sometimes as much as a pint will be passed in about a half hour later. The colon of an infant 6 weeks old will hold one pint without distention; a child of 2 years from two to three pints.

Hot or cold water, plain or antiseptic, may be used as an irrigating fluid. Sometimes very hot water will afford marked benefit, as in great prostration or in a total collapse. I prefer water at temperature of 100 to 104° Fahr.; water below this will cause contraction of muscular coats, and prevent thorough irrigation. Sometimes when body temperature is very high it will be considerably lessened by gradually reducing temperature of irrigating fluid, and thus preventing the shock from suddenly flushing with ice water. It is often advisable to introduce at the end of irrigation one pint at temperature of 70° Fahr. It has a tonic effect on the mucous membrane, relieving the pain and tenesmus, and is also favorable on a high body temperature; but, generally speaking, the temperature of the fluid should be about equal to that of the body.

The frequency of irrigation is determined by the number and character of stools; at first two to three times a day, then once a day. The character is a better indication than the number. As pain and tenesmus lessens, blood and mucus decrease, it may be given at longer intervals than six hours, and later when stools border on the normal a daily irrigation for a few days may prevent a relapse. It is never necessary to administer any local anæsthetic and rarely necessary to precede with a stimulant.

As to antiseptics, the best one I find is the common salt solution of the surgeon, a teaspoonful of common salt to a pint of water. As much of this is used as is necessary to get return flow clear, sometimes three to four quarts; then follow by the injection of two tablespoonfuls Sub-nitrate of bismuth to a pint of water solution, after which immediately withdraw the catheter, allowing the Bismuth to remain and thoroughly coat the lining membrane of the intestines. A Bi-carbonate of sodium solution is sometimes useful instead of salt, and also Peroxide of hydrogen is beneficial when there is much inflammation and mucus present. Other antiseptics are legion, from Boracic acid to Zinc; they all have their peculiar advantages, but few contain them all as the salt and Bismuth solutions. The greatest benefit is from the cleansing. Occasionally in ulceration of colon irrigation with Nitrate of silver, 5 to 20 grains to pint, is helpful; but it should never be used in acute stages and rarely in the chronic.

Irrigation will empty the colon, but it is soon filled by the descent of material from the small intestines. It seems that peristalsis is much hastened by washing the colon. It often happens, therefore, that in a little time the colon may contain almost as much as when first washed out, and the irrigation must of course be repeated; thus more rapidly getting rid of the results of putrefaction, decomposition and fermentation; the pain and straining and tenesmus are mitigated and oftentimes entirely relieved, and will also just as surely relieve the vomiting when produced reflexly, as it will relieve the bowel itself.

Irrigation is contra-indicated only in very feeble children, or where collapse is impending. It is applicable in all stages, and with ordinary cases is free from danger, and in my experience has never done harm. I feel sure you will find your successes, both as to time and cures, will be greater than without using it, and in chronic cases you will come to rely on it quite as much as medication through the mouth and stomach.

CHOLERA INFANTUM.

J. H. SANDEL, M. D., PLYMOUTH.

I SHALL attempt to present this subject, for your consideration, briefly; although it is ever of importance.

It may properly be characterized as a grave form of infantile diarrhœa, with symptoms closely resembling those of true cholera. Chiefly among these are frequent and persistent vomiting, copious serous dejections, high fever, and a rapidly-developing condition of collapse.

Symptoms.—After a variable period, usually characterized by uneasiness, abdominal discomfort and a rising temperature, the child begins to vomit; and at the same time, or shortly afterward, purging supervenes. The vomiting is usually frequent at first, the contents of the stomach are ejected, next a little bile-stained mucus, and, lastly, nothing but a serous fluid. The evacuations from the bowels soon assume the same serous character. They lose their fæcal appearance and acid reaction, consist mostly of a colorless fluid, copious in quantity, seemingly often out of all proportion to the amount of fluids taken, alkaline in reaction, and generally with a peculiarly musty odor.

Pain is not often a marked feature. The temperature is elevated, often rising to 104 and 105° Fahr., although the body feels cool to the touch. Thirst is decided, but drinks and foods of all kinds are rejected by the stomach shortly after they are taken. With such a drain upon the fluids of the body the loss of weight and strength is rapid, and in a few hours the appearance is greatly altered. The face becomes pale, the eyes sunken, the features pinched, and the expression anxious. During the early hours restlessness is a marked symptom, but as the strength fails this is replaced by a condition of apathy, which later on may develop into the hydrocephaloid state, the spurious hydrocephalus of the older writers. Should the disease continue the child will lie in a semi-comatose condition, with head drawn partly backward, pupils sluggish, abdomen retracted, and respiration irregular and jerky, at times of the Cheyne-Stokes type. There may be also twitchings of the arms and legs. Towards the end the patient becomes more and more comatose, or an attack of convulsions may supervene and usher in the close of the scene.

Etiology.—The exact nature of cholera infantum has not yet been fully determined, but it is now generally considered as being a toxic condition produced by the absorption, from the intestinal canal, of some special toxins originating in fermenting or decomposing food. The prolonged heat of the months of July and August is undoubtedly a predisposing factor. Children living under faulty hygienic conditions, and supplied with an injudicious dietary or with milk food in the preparation of which due care has not been taken, are among those most prone to be attacked. While the disease may develop suddenly in the apparently healthy, yet we will usually find that there has been a more or less severe antecedent gastro-intestinal disorder.

Diagnosis.—This is usually easy; the character of the onset, the persistent vomiting, the profuse serous discharges, the high temperature and the symptoms of collapse developing in a few hours form a picture unlikely to be mistaken for any other condition.

Prognosis.—Few diseases require us to be more guarded in our prognosis. While there is no doubt that under good, careful homœopathic treatment we will witness more recoveries than under any other form of treatment, yet under any treatment fatal results are, at times, likely to be experienced. The younger the child the higher the temperature; the hotter the weather, and the more unhealthy the surroundings, the more hopeless the case.

Treatment.—Regarding the disorder as a toxic condition due to the absorption of ptomaines from the alimentary canal, the popular

treatment of the day suggests that the first efforts must be directed to cleaning out this tract as promptly and thoroughly as possible. For this purpose a few grains of Calomel combined with Sodium bicarbonate are to be given in divided doses. The stomach is to be thoroughly washed out with a tepid weak solution of Sodium bicarbonate (½ drachm to the pint). Next the whole tract of the colon is to be irrigated with a saline solution (1 drachm Sodium chloride to the pint). To insure the passage of the solution into the higher portions of the colon the hips must be well elevated, and the tube passed well up into the bowel. The solution should be of a temperature of from 100 to 105° Fahr. and be allowed to run into the bowel in a gentle, steady stream from a fountain syringe placed at a height not exceeding two or three feet. These irrigations are to be repeated every hour or less often, according to indications. I have had no experience with this treatment; some of you may have had, and would therefore be in a position to speak.

Quiet is essential to successful treatment. The thirst should be assuaged by giving cool water, toast water, rice water, or albuminized water in small quantities oft repeated. The fever may be mitigated by cool sponging. Little or no nourishment of any kind is to be given during the acute stage of the disease; milk especially seems harmful, and should not be administered during the first 24 hours of the disease. The digestive functions at this time are almost in abeyance, and any food administered will either be at once rejected by the stomach, increasing the hyperæmic condition, or, if retained, will likely feed the fermentation. As the vomiting and purging subside, and a condition of general improvement sets in, there may be a gradual return to the child's accustomed food, given at first in small quantities well diluted; to this Bovinine may be added to advantage. This may often be interspersed with light broths.

Remedial Treatment.—The remedies most often called for in this disease are Veratrum album, Ipecacuanha, Podophyllum, Arsenicum, Cuprum arsenicum, Cuprum, Æthusa cynapium and Iris versicolor.

Veratrum Album.—This is in many cases the first remedy to be thought of. It is indicated by the suddenness of the attack, the copious watery stool, violent vomiting, the cold, clammy perspiration, especially on the forehead; decided exhaustion following the vomiting and purging, great thirst and cravings, but each drink excites vomiting. A few hours' sickness causes great prostration.

Ipecac.—Nausea and vomiting predominating; there is continued

nausea, stools are green as grass or fermenting like yeast, face pale and sunken, blue rings around the eyes.

Arsenicum.—Stools green or dark, watery and offensive, repeated vomiting of a brownish watery substance, excited by drinking; decided thirst, drinks little and often; great restlessness, anxiety and prostration; useful in the later stages of the disease and in children who have been injudiciously fed.

Cuprum Arsenicum.—When, besides the general symptoms of Arsenicum, nervous symptoms and cramping pains are prominent features; a good remedy to begin painful cases, with a sudden onset, if no other remedy seems clearly indicated: a good general remedy.

Cuprum.—Painful cases with green stools, vomiting or ineffectual efforts to vomit relieved by cool drinks; especially indicated when there is a tendency to convulsions from the beginning; cramps which affect especially the flexors; the muscles are often drawn into visible knots.

Iris Versicolor.—A valuable remedy in cases less severe than those calling for Veratrum; the stools are thin, watery, copious, bilious and sour; vomiting of sour fluids; much pain and distress.

Besides the above, we should keep in mind, as additional remedies, Calcarea, Chamomilla, China, Croton tiglium, Ferrum phosphoricum, Magnesia carbonica, Phosphorus, Podophyllum and Secale.

Cases of cholera infantum should be seen often whenever it is possible to do so in order that we may promptly meet the ever-changing conditions.

For the hydrocephaloid condition which often ensues the main remedies are Apis, Bryonia, Calcarea carbonica, Carcarea phosphorica, Cuprum, Helleborus niger, Phosphorus, Sulphur and Zincum metallicum.

Under good careful treatment the majority of *these* cases recover.

DISCUSSION.

Dr. A. P. Bowie: There is a remedy that is useful in this disease, and that is Aconite. I do not believe that the only indication for Aconite is fever. I prescribe it less in fever than in any other conditions; but there are cases of cholera infantum in which I cannot get along without the use of Aconite, and these are cases I can generally trace to cold, to the influence of cold in producing the disease, and in these cases I think Aconite acts beautifully.

As to the first treatment the doctor mentioned, which I am very glad to say he has never used, I think it only needs to be mention-

ed to be condemned, because there is no homœopath certainly who would use that sort of treatment in cholera infantum.

Dr. G. J. Berlinghof: The doctor says: "I have used rectal injections sometimes." My first experience with the tube was not satisfactory, because it was not inserted into the colon as it should be. Many people who use the rectal tube put it into the anus and expect it to follow the sigmoid flexure. If you will insert one finger and pass it up into the sigmoid flexure, irrigating the bowel with an antiseptic solution, or, if you please, sterilized water, you cannot help to get results. I have seen many cases benefited by it. It acts not only as a cleanser of the alimentary tract, but some of the water injected into the bowel is absorbed and taken up into the tissues, and many times invigorates a patient in a low nervous state.

Dr. J. W. Thatcher: I take exception to what the doctor says. I have not seen a case in which the homœopathic remedy given in potency form would not bring the result, and that is where we stand today. How often it is said the two schools are coming together. Why? Because on account of practice. You don't depend on the remedy, and when you do get a result you give credit to the other medicine. Just as in antitoxin, the homœopathic remedy is given and no credit is given when it is the source of good results.

Dr. J. H. Sandel: I said in my paper that I never tried irrigation; but since looking the matter up and giving the matter thought I recall to my mind two cases I saw last summer which were in a condition of collapse, and in which I gave an unqualifiedly unfavorable prognosis. If I saw another case like that I should surely use the rectal irrigation, for the reason that it might give an opportunity to do something in addition to the indicated remedy. If we ever get to the point where the indicated remedy will accomplish everything I will be happy (I never use anything else but the indicated remedy in cholera infantum); but I have not got that far yet, and my visions of the future do not tell me I will get there within the next few years. I will do everything to save my patient and lower my death rate, and for that reason if I again get cases like the two I referred to as having been under my care last year I would try irrigation with saline solution in the hope that I might gain time to do something with the indicated remedy, which in this case I did not have. The cases were all in a collapsed state when I first saw them and died within a few hours, where I might have prolonged life and given the remedies an opportunity to act, which I did not have the privilege of doing.

REPORT OF THE

SECTION OF SURGERY.

Gall Stones, by J. W. Coolidge, M. D.
Diagnosis and Treatment of Acute Gonorrhœal Prostatitis, by L. T. Ashcraft, M. D.
Some Remarks on a New Dusting Powder, by Daniel J. Baker, M. D.
Some Affections of the Liver Requiring Surgical Treatment, by W. Louis Hartman, M. D.
A Case of Dynamic Ileus, by J. L. Peck, M. D.

GALL STONES.

J. W. COOLIDGE, M. D., SCRANTON.

It has been tritely said by somebody that when doctors become skilled in any particular line of ills they always have a flood of that particular thing to deal with. That the specialists of today have split the practice of medicine and surgery down to pin points is unquestionably true, and that the organ we know the most about is expected to stand up and give an account of itself the oftenest is, I opine, likewise true.

The subject of gall stones has impressed itself upon my mind, not by reason of vast experience along that line, nor by reason of finding the cases easy of diagnosis, but rather because of the obscure and confusing symptoms and conditions that ofttimes make the diagnosis problematical. Affections of the hepatic region, it strikes me, are about on a par with pelvic disorders in regard to differential diagnosis. How often we have those cases of illy defined pain in the upper abdominal region simulating gall stone attacks, but not clearly enough defined to make an immediate diagnosis. A positive diagnosis must be made if, in a case demanding surgical interference, we would avoid the humiliation of finding no stones after an abdominal section undertaken for their removal.

How, then, shall we classify our cases so as to be sure on this point? The classical symptoms upon which a diagnosis would be based are, first, subjective. Pain.—Sharp, colicky pain in the hepatic region, the abdomen, or stomach, vomiting, and derangement of digestion, constipation or diarrhœa, with clay-colored stools; chills with increased temperature at time of attack, jaundice, itching of skin, slow or feeble pulse, and numberless nervous and emotional disturbances, such as muscular convulsions, fainting, persistent cough and hiccough.

Objective symptoms: Hepatic tenderness, enlargement and sensitiveness of gall gladder, bile in the urine, and concretions with the fæces.

While such an array of symptoms should be present in a typical gall stone attack, it is rare that we find a case so clear cut. In many cases the stones will not be found, particularly if we leave it to the nurse or the attendants to find them. Only a most careful inspection of the bowel discharges for at least one week after an attack; if not sooner discovered, by straining through a fine wire screen or cheese cloth under a tap of running water will make their discovery certain when present. At times, then, we will find only decomposed crystals of cholesterine. If in doubt, a microscopical examination of such sediment should be made to determine the nature of the crystals. The concretions are not always found in undoubted cases; that is to say, the concretions may not have escaped from the biliary passage, or they may have been completely broken up in their passage through the bowel. The fact we do not find them does not always negative the diagnosis.

In the absence of the stones the subjective symptoms are most important. Pain is the most characteristic; pain radiating into the chest or into the abdomen or back. It may be slight, or so severe as to produce convulsions or even death; dull, agonizing, cutting, or contractile pain. It may be sudden or gradual, preceded by malaise, bitter taste in the mouth, or heaviness and weight in the epigastrium, or it may come on suddenly while in perfect health. It is generally paroxysmal, and usually begins in the vicinity of the gall bladder; and as a rule the attacks come one or two hours after meals, particularly full meals. The time of occurrence is a most important differential point in favor of gall stone origin of the pain. Neuralgia of the stomach, intercostal neuralgia, gastric ulcer, pleurisy and pleurodynia are frequently confused with these attacks, and are common diagnoses.

Floating kidney offers points of resemblance, as the attacks of pain so caused are apt to be paroxysmal; but the history will help differentiate. One has its associated urinary symptoms, the other digestive biliousness, so-called. In the former when in a supine position the tumor tends to fall back; in a distended gall bladder it does not, but rather to push forward. In the former the tumor does not vary in size unless there is hydronephrosis, is not sensitive to touch; in the latter the tumor does vary in size, or may disappear and is sensitive. The former is kidney shaped; the latter, pyriform.

In appendicular abscess there is the early history, the common symptoms referable to McBurney's point, etc. A gall bladder may then be so distended as to simulate very closely either a floating kidney, a hydronephrosis, or an appendicular abscess, and many nice points of differential diagnosis are likely to arise in clearing up such cases.

The symptom of jaundice is important, but it occurs in so many abdominal troubles that it is far from being characteristic. Inflammatory swellings of the mucous membrane of the biliary passages may obstruct the ducts and even obliterate their lumen, thus producing jaundice with clay-colored passages, bile in the urine, itching of skin, and, in fact, about all the symptoms of gall stones minus the stones. On the other hand, gall stones may be present without jaundice, as in the case of occlusion of the cystic duct with, perhaps, atrophy of the bladder. I would look upon enlargement of the gall bladder, when present, as next to pain the most important diagnostic symptom. But such enlargements will only be found in a lesser number of cases and will not be present when there is no permanent bile obstruction, and when present, in a certain per cent. of cases is detected with difficulty where the abdominal walls are loaded with fat or where an enlarged lower lobe of the liver completely covers the gall bladder. When present the tumor is usually found depressed from the region where it normally belongs, at about the prominence of the tenth rib, is pyriform in shape and extends downwards and inwards towards the umbilicus. However, varying conditions, as a dilated stomach, may change both its position and shape.

It is well to be remembered that where the gall bladder cannot be mapped out with the patient lying upon the back, by turning him over flat upon the face and abdomen one will at times be enabled to better determine the condition of liver and bladder.

Malignant disease of the biliary passages with jaundice and distended gall bladder must be excluded in diagnosis. Occurring, as

such cases do, at times with cholelithiasis, the question of cause and effect will naturally arise. So far as I can recall, the cases of malignant disease of the biliary passages that I have seen post-mortem have been accompanied by distention of gall bladder whether stones were present or not. I believe in these cases the early history most largely determines the question of diagnosis. In malignant disease the pain is not so severe. At first it increases gradually and is persistent; the jaundice gradually deepens and never disappears.

The treatment of gall stones is hygienic, medical, and surgical. While in past years I have had no cases in my private practice that have urgently required or received surgical treatment, I think some would have been better managed by surgical measures. But as there has been no mortality and some cures, I do not think I would now make a case a surgical one until both hygienic measures and remedies had been thoroughly tested. If called during the attack I do not hesitate to employ any remedy that will relieve, and this, I must confess, is usually non-homœopathic, such as hot fomentations, high up rectal enemas of oil or water, hot water per mouth, olive oil, chloroform preferably by mouth in water, or even morphia. I mean to say that I depend upon such measures for palliating the attacks rather than the old line of indicated remedies prescribed in our text-books. They have been tried and found wanting. I have repeatedly tried Hughes's recommendation of Calcarea carbonica, which he so unqualifiedly endorses, but it doesn't work with me.

As these attacks last from one to twenty-four hours or longer, they must be palliated or great suffering and prostration will follow. If a case does not yield to about this line of treatment, there should be no hesitation in opening the abdomen, searching for and removing the offending calculi. A case should not be allowed to suffer long and repeated attacks of bilious colic, and the general health and vitality of the patient become used up for lack of surgical skill. An exploratory incision is attended by little risk.

When a surgical case is found to be non-septic and the common duct is open the gall bladder should be incised and the calculi removed, the wound sutured, the sac pushed back into the abdomen and the external wound closed. I believe this is safer and better surgery than to establish a fistula, which may not close and which most likely will not if the old method of suturing the gall bladder to the skin is employed.

I now have a couple of patients who have had this operation done elsewhere, and they will not submit to the necessary secondary work

of closing up the opening. Of course if the case is septic drainage, either external or by anastomosis, will be required.

In cases amenable to medical treatment I have seen good effect from the use of Chelidonium, China and olive oil, and I believe these remedies are important about in the order named. I have seen a number of recurring cases broken up by the use of Chelidonium IX, three or four doses daily. I believe very much in the olive oil treatment and I have my patients get it direct from the Olive Growers' Association, of California, by the case. It is best administered in milk, one or two tablespoonfuls several times a day.

DIAGNOSIS AND TREATMENT OF ACUTE GONORRHŒAL PROSTATITIS.

LEON T. ASHCRAFT, A. M., M. D., PHILADELPHIA.

It is impossible to state how often gonorrhœal prostatitis occurs without reviewing the records of both my clinical and private practice. Approximately, however, about 90% of *chronic* gonorrhœics present unmistakable evidences of its presence. This will be readily appreciated when we consider the relationship existing between the deep urethra and the prostate. Indeed its frequency has so impressed Wossidlo and Valentine* that they have emphasized this point, that no patient suffering from a chronic urethritis shall be discharged cured until the prostatic secretion, expressed by rectal massage and washed out per urethra, be examined and found free from gonococci. It is my unvarying custom to follow this plan.

Prostatitis is a frequent complication of an acute specific urethritis, but its occurrence depends entirely upon the method employed for the cure of that condition. Those who employ no gonococcidal agents will be rewarded by a considerable experience in the treatment of this condition. A similar fate awaits those who are unskillful in the use of the irrigating apparatus, or those who insist upon urethro-vesical irrigation when only the anterior canal is invaded. Briefly, well managed cases of acute gonorrhœa show a very low percentage of prostatic complications. I can recall but few occurring in my private practice.

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*Valentine's "Irrigation Treatment of Gonorrhœa."

Unnecessary and clumsy sounding, catheterization, alcoholic, sexual and dietetic indulgences are also responsible for infection. Again acute gonorrhœal prostatitis may occur months and years after the apparent cure of an active urethritis in the following manner: It is a well-recognized fact that many men, particularly those who have a congenitally contracted meatus, are annoyed by a thin mucoid discharge, usually the result of an erosion or a stricture of large calibre,* or by some catarrhal condition of the prostate and its appendages, or from a sub-acute inflammation of the seminal vesicles.** In such cases, when these organs are in a state of passive hyperæmia, it is not infrequent to see an acute inflammation of the prostate result from an awakening of the gonococci already harbored in these localities by reason of an acute and active hyperæmia caused by cold, highly acid state of the urine, or from sexual and alcoholic excesses. Again in prostatiques accustomed to catheter life, who in earlier years have been victims of gonorrhœa, it is not infrequent to see an acute prostatitis, manifestly caused by the irritation of frequent catheterization. And, too, although infrequently, the condition may arise by means of a lymphatic extension.

The mildest expression of acute gonorrhœal prostatitis is the follicular form, in which the pus has entered into one or more ducts of the prostate and confined itself to a very limited area. In such cases the subjective symptoms are but a slight exaggeration of those associated with acute posterior urethritis, varying of course with the extent of the parenchyma involved. Urination is more frequent and painful, and the pain more acute, owing to the contact of the urine with the highly injected mucosa. An inspection of the urine voided into two tubes will show both very cloudy, particularly the second; indeed, a few drops of blood may be seen in the fluid caused by a rupture of the smaller capillaries. The congested and swollen organ causes a sensation of fullness and weight in the perinæum and pains along the spermatic cord and in the thighs. The rectum, too, participates in the morbid process; tenesmus and even hæmorrhoids result from irritation of the sphincter ani, caused by the prostate infringing upon the rectal lumen. There is more frequent urging to defecate, pain being associated with the passage of stools. Rectal examination detects areas of sensitiveness and particularly so when the ex-

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*Diagnosis and Treatment of Stricture of Large Calibre.—Report from Hahnemannian Monthly, March, 1898.

**Seminal Vesiculitis.—Report from Hahnemannian Monthly, April, 1899.

amination finger is passed over the deep urethra. The sphincter ani is tightened and the urethral discharge is somewhat suppressed.

Naturally these symptoms produce a varying degree of constitutional disturbance. All are invariably magnified in the diffuse type. After a few days of mental and physical depression a chill usually announces the complication, the pulse becomes decidedly quickened and the temperature rises to 102 or 103° Fahr. The urinary symptoms are now decidedly annoying and painful, desire to urinate imperative, and a varying degree of urinary retention is present, the swollen prostate infringing upon the capacity of the bladder. Suprapubic pains are present, while the distress referable to the perinæum and rectum is truly agonizing.

In order to obtain an intelligent idea of the extent of the tumor rectal examination must be made, even though it causes the patient much pain. As in the follicular type, the gonorrhœal discharge is usually entirely suppressed.

Some doubt exists concerning bladder inflammation as a complication; this will, however, depend somewhat upon the previous existence of a cystitis. Should such exist it will undoubtedly be intensified. Usually there is a degree of vesical infection. .

I have purposely deferred mentioning one of the most important complications—prostatic abscess and suppuration. It is necessary for me to mention, however, that it may arise in its several manifestations in any variety of prostatic inflammation, follicular, diffuse and indeed in the senile variety. As a sequel the prostatic ducts are occluded and the formation of retention cysts and abscess cavities results. In the follicular variety these abscesses are usually circumscribed. In the diffuse they frequently involve the entire cavity, making one large area of suppuration. More rarely the entire gland is involved, producing a peri-prostatitis, and in some instances not only the gland is affected, but the structures surrounding it, terminating in a para-prostatitis. The symptoms associated with this complication vary with the amount of tissue involved. The local symptoms are all intensified, rectal touch revealing one or more areas of bulging, or the entire gland fluctuating. The constitutional symptoms of this complication are usually severe,—chill or chilliness, high pulse and temperature, coated tongue and constipation, and in severe cases the patient even sinks into a typhoid state.

It is not very difficult, especially in the presence of these symptoms, to recognize gonorrhœal prostatitis. A mild follicular type may be mistaken for posterior urethritis, and severe manifestations of this

variety are cleared up by rectal touch, which reveals the areas of prostatic tenderness.

The diffuse form may be mistaken for seminal vesiculitis, and to differentiate between these conditions is difficult, since frequently coincident involvement of the seminal vesicles and prostatitis exist. However, where the vescicles are involved the examining finger will usually detect two swollen bodies situated well above the prostate. In addition there is always marked disturbance of the sexual function indicated by frequent pollutions, as well as those urinary disturbances which accompany prostatitis; hence the difficulty in differentiation.

This condition may also be mistaken for cystitis. In cystitis unassociated with prostatitis the urine will be alkaline, loaded with pus and other micro-organisms, and the calls to urinate will be more frequent and painful. Also the examining finger will fail to detect any marked engorgement of the prostate.

Complete retention of urine dependent upon filiform structure may be mistaken for acute prostatitis, but rectal touch again fails to reveal any prostatic engorgement, unless, of course, the latter complicates such a stricture. It is, sometimes, difficult to differentiate between senile enlargement and acute prostatitis, since in some cases acute prostatitis frequently complicates senile enlargement of the prostate. However, a swollen and moderately compressible prostate will usually warrant the diagnosis of acute prostatitis. Abscess or impending suppuration is readily distinguished from the other acute types by the temperature, chill and rectal touch, thus detecting one or more small cavities, or the gland one whole fluctuating area.

Life may well be despaired of in the graver forms of acute prostatitis, especially when suppuration takes place and the process terminates in abscess formation which may rupture into the urethra or rectum or both, and in some instances even into the surrounding structures. In such cases the patient sinks into a typhoid condition, from which he never rallies unless proper surgical interference is instituted.

Unskillfully treated cases sometimes result in urethro-vesical or vesico-rectal fistulæ, or, when miliary abscesses have existed, areas of chronic suppuration may develop and furnish a source of contagion and a low grade of pyæmic infection; thus continuing gonococcic infection. While life is not threatened in the diffuse form, many grave consequences present themselves. In some instances the tumor may occlude the urethral lumen, producing urinary reten-

tion. Particularly is this so when an acute infection is implanted upon a prostate already hypertrophied by senile changes. Not infrequently I have been called upon to catheterize such cases, and in three instances, by reason of inability to introduce any instrument into the bladder, have been compelled to resort to supra-pubic puncture. Not all cases of the diffuse variety progress to suppuration. However, it is indeed rare when there is complete "restitutio ad integrum." They usually subside into a chronic hyperæmia invalīding the patient, rendering his life miserable, and producing all the symptoms with which we are so familiar. The same may be said of the follicular type. It is rare, however, that a prostatitis is ever entirely cured. Exception to this must, however, be made in favor of those mild cases which are but slight exaggerations of posterior urethritis.

Treatment exhausts almost every therapeutic means. There are, however, certain lines applicable to every form. All local measures, such as injections and irrigations, are positively contra-indicated, exception of course being made to catheterization for urinary retention.

Rest in bed is desirable, even in a mild follicular attack of prostatitis, because it may prevent the development of the diffuse form, or, indeed, of a peri-prostatic abscess.

It is hardly necessary to restrict the diet of the mildest type, but the prohibition, of course, must be made of alcoholic indulgence. In severe follicular infection a moderate diet is desirable, and, of course, in the diffuse variety the diet should consist largely of skimmed milk.

In the beginning of an attack it is advisable to empty the bowels, since constipation and the subsequent passage of hardened fæces only aggravate the patient's suffering.

Fever, when present, may, in its incipiency, be controlled by Aconite; threatened pus formation calls for Hepar. Should constitutional symptoms arise, as in the severe forms of infection, the totality of the presenting symptoms will at once suggest the remedy to an experienced prescriber. Internal remedies must be administered with the two-fold idea of subduing the pain, strangury, tenesmus and frequency of urination. and as well preventing, or, at least, combating, urinary sepsis. With this in view for the former symptoms, I know of nothing better than Cantharis or Terebinthina. Pulsatilla must always be thought of for its therapeutic action in urinary metastasis.

Urinary asepsis can be secured by urotropin.

Although I have deferred mentioning the treatment of prostatic conditions by way of the rectum, I have done so simply because it is

only through this avenue that our most brilliant results are obtained.

I cannot lay too much stress upon the value of Ichthyol. It is my custom, in all prostatites, to make a daily application of a 25% aqueous solution with Martin's rectal speculum.

Rectal suppositories consisting of ½ grain of Opium to 15 grains of cocoa butter are of use when pain is an important factor. They should be administered morning and evening.

Retention of urine caused by enormous tumors demands either supra-pubic puncture or incision in the event of unsuccessful catheterization.

Abscess formation necessitates perineal drainage. Fortunately, however, mechanical measures except in prostatic suppuration will meet all the requirements of amelioration.

DISCUSSION.

DR. H. L. NORTHROP: The homœopathic surgeon, if there is such an individual, insists upon the full meaning of the adjective. He has been crossed so often by homœopathic physicians that when the homœopathic surgeon has a remedy to speak of it gives him pleasure to mention it. It is, therefore, with great pleasure that I speak of two remedies that I have found of considerable service in the treatment of prostatitis, not decrying any of the remedial means Dr. Ashcraft has mentioned, but simply saying many years ago these cases baffled me. I have been unable to improve them, and this undoubtedly has been the experience of many others, because they are here to try and improve. During the past two years I have found, after studying the materia medica, which I have done years ago, that Conium and yellow Iodide of mercury are good remedies. Apparently, as far as I am able to judge, at present they are valuable in acute and chronic cases, combined with local treatment, which should be as mild as possible, the milder the better. The treatment mentioned by Dr. Ashcraft—I believe that was the title of his paper—has covered the ground very completely, and although he did not mention injections, which are of use in the deep urethra, in the prostatic urethra Sulphate of thalium and Nitrate of silver are valuable. If I remember, the doctor did not mention the stripping of the seminal vesicles, which is an aid in the treatment of prostatitis.

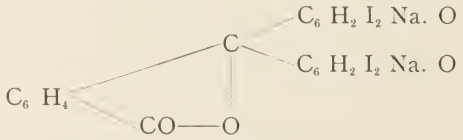
SOME REMARKS ON A NEW DUSTING POWDER.

DANIEL J. BAKER, M. D., PHILADELPHIA.

THE question as to whether a dressing shall be wet or dry is one which arises in connection with every surgical case that applies for treatment. Patients as a rule prefer dry dressings, as they only view the situation from the standpoint of personal comfort, and some are not backward in presenting requests or even making demands for their application. Physicians are sometimes led into error through fear of giving offence, and surgical conditions are treated with cerates, unguents, ointments, etc., and allowed to run on for weeks or even months, when a few successive dressings, at almost any time, with one of the stronger antiseptics would cure the case.

I am sure that every one who has had much experience in hospital and dispensary work will concur in the statement that every antiseptic, dusting powder or other local application has a certain limited sphere of action which is more or less difficult to describe, although very simple and well-defined to those constantly using it. Until recently we have had to use wet dressings when antisepsis was required, following these with one of the dusting powders when cleanliness of the wound had been secured. There is now a preparation on the market, known as Antinosine, which has a powerful antiseptic action combined with the usual healing properties of a dusting powder. By courtesy of Dr. William B. Van Lennep, and the generosity of the manufacturers, I have been able to experiment with it in the Dispensary of Hahnemann Hospital, the object of this paper being to state the obtained results.

Antinosine is described by Ohmann-Dumesnil, in the St. Louis Medical and Surgical Journal of March, 1899, as "The sodium salt of tetra—iodo—phenol—phtalein, having the following structural formula:—



It is a dark blue, amorphous powder which is rapidly soluble in water and alcohol. Continued exposure to the Carbonic acid of the

air will decompose it into Nosophen and Carbonate of soda. It has the advantage of being non-toxic, non-irritant and odorless."

To this description I would add that its antiseptic action seems to be due to the liberation of nascent iodine in the tissues to which it is applied, as it is very rapidly dissolved by the secretions of the parts, coloring them and the dressings a dark red and giving off the characteristic odor of that drug. Its special sphere of action seems to be in connection with open wounds where the tissues are infiltrated with pus, with either much or little discharge—such a condition as remains after an abscess, furuncle or other infection has been incised. If such a wound be thoroughly cleansed, and Antinosine applied, the beneficial result will often be startling in its rapidity. In such cases I am in the habit of using the powder in full strength. In conditions requiring but mild antisepsis, excellent results may be obtained by mixing it with as high as four or even nine parts, by bulk, of Boracic acid. A strong solution in water is the best form in which to inject it into cavities, fistulæ, sinuses, etc. (such as stitch abscesses). In this form it may also be used for saturating plain gauze for application to open wounds. It is highly recommended by Ohmann-Dumesnil as a dressing for leg ulcers, using it as a powder in full strength.

It may not be inappropriate at this point to mention a few precautions to be observed in order to secure its best action. All suppurative products must be thoroughly removed at each dressing. It should not be dusted on the wound too thickly, because a crust is sometimes formed over the whole wound before the suppuration has been completely stopped.

All loose crusts and those not firmly attached should be removed at each dressing. If the suppurative process is very obstinate, so that a prompt action on the part of Antinosine is not forthcoming, a single application of one of the stronger wet antiseptic dressings will often give it the necessary start. By observing these few rational precautions in connection with those usually adopted in wound treatment, it will be found to be the most rapid antiseptic and healing agent in suppurating wounds that has yet been produced. Its added advantage is that it may be used as a dry or wet dressing, as preferred.

For a like rapid action in clean wounds use Nosophen—dry.

As a proof of the merits of Antinosine, let me cite a few cases, the first of which was seen in private practice, the remainder being dis-

pensary cases. I purposely gave the preparation a severe test, selecting the worst available cases for experimental purposes.

Case 1. An elderly lady with an excessive adipose development, who complained of a large lump on the outer side of the left thigh, a little below the level of the lesser trochanter. Cause, traumatism. First seen by me on December 2, 1899. The external manifestation was a dark purplish, tense, very painful mass about the size of a half walnut. Surrounding this, but in the sub-dermal tissues, was a sensitive inflammatory mass larger than an equatorial cross section of a base ball, somewhat irregular in shape and of considerable thickness. On December 3 the external mass was fully incised and but little pus evacuated, that being mostly expressed from ragged sinuses extending in several directions into the deeper mass. Radical treatment under an anæsthetic was impossible owing to an old heart lesion, so daily wet dressings of Bromine 1-500 were applied until December 22, when the suppuration had nearly ceased, but the deep inflammation was still present and the wound had shown no tendency to heal. Antinosine was first used on December 23, with good results manifested within 24 hours. It was reapplied for a few days every 24 hours, then every 48 hours, then every 72 hours. On January 5, 1900, the inflammatory mass had disappeared and the wound had completely healed. It has since given no trouble.

The condition in this case was very similar to that found in carbuncle.

Case 2. J. McK., adult male; laborer. Left index finger had been so crushed in machinery as to necessitate its amputation at the metatarso-phalangeal articulation. As often follows in such cases, there was infection with persistent suppuration in the stump. It was variously dressed for two weeks without much improvement. Antinosine begun March 26, 1900, and under daily dressings the stump entirely healed by April 9.

Case 3. J. H., age eight, male; school boy. While playing with a dog was thrown or fell, striking his forehead against a stone curb. A wound 1¼ inches long was sewed in the receiving ward. First seen by us April 10, 1900, and as signs of infection were present a formaldehyde compress was applied. April 14 returned and wound was reopened and enlarged from a line to a Y to evacuate several ounces of pus which had burrowed under the scalp. Patient sent into hospital. Returned April 16 for daily dressings of various kinds, which produced but little effect. May 10 daily dressings with Antinosine begun. The full strength powder was sprinkled on the

wound externally, and carried in by a plain gauze pack. June 5 wound completely healed except for a small sinus. Antinosine stopped and silk-worm gut drain inserted. June 8 drain removed and carbolized gauze and a pressure bandage applied. June 11, discharged.

Case 4. In contrast with Case 3. W. D., adult male; iceman. Lacerated infected scalp wound caused by being run over by his own wagon. First seen by us June 18, 1900. Suppuration being present, the wound was opened, exposing about a square inch of skull. The flap, which was V shaped, quickly retracted, compelling us to heal the wound by granulation. This case is still under treatment (September 27), although nearly healed, and has had various antiseptic dressings of the usual type.

In these cases the wounds were of about the same size, but in Case 3 the wound was slightly larger and large quantities of pus were discharged. In Case 4 there was but little pus, but the skull was exposed. Next to tubercular conditions and leg ulcers, infected scalp wounds are probably the most difficult cases to treat.

Case 5. I. T., school girl, age about eleven. Infected finger. First seen April 17, 1900. Incised next day and variously dressed until May 9. By this time, the suppuration and sloughing having been very persistent, nothing but a shell of tissue was left of the terminal portion of the finger, with the phalanx lying at the bottom of the wound partially exposed. Pure Antinosine was now applied, and on June 22 the wound had filled up and some redundant granulations were removed and the wound redressed with Bismuth subiodide. Discharged at the next visit. Throughout the treatment the patient was very irregular in attendance, sometimes allowing one or two weeks to elapse between redressings.

Case 6. D. M., adult male; salesman. Infected thumb, later going on to palmar abscess. First seen by us June 7, 1900, and treated with the usual dressings until June 28, when he was sent into the hospital for operation. Returned July 10 with sinuses in palm and large open wound around base of thumb, and the palmar tissues badly undermined. Variously dressed until August 1 without much progress. On that date daily applications of Antinosine were begun after the manner described under Case 3. August 8, patient discharged completely healed.

Case 7. M. S., female, aged about sixteen; paper boxmaker. Crushed finger—distal phalanx. Admitted February 28, 1900. Variously dressed, but the wound persistently refused to heal.

May 8, Antinosine applied.

May 10, same dressing.

May 12, suppuration stopped and wound nearly healed. Iodoform and Boracic acid applied.

May 14, same dressing.

May 26, discharged—cured.

Case 8. E. M., ladies' maid. Infected thumb—infection later extending to forearm. Admitted June 1, 1900, and usual daily treatment adopted.

June 18, sent into the hospital for operation.

July 11, returned and daily dressings of the usual type resumed with complete success.

The flexor tendon and cicatrix of the thumb were badly contractured, and on September 10 the cicatrix was excised and the tendon stretched. Usual dressings applied.

September 19, some tendency to suppuration, which was promptly checked by Antinosine and Boracic acid. The wound is now healing kindly under daily dressings of this mixture in the proportion of 1 to 4.

In explanation, let me add that the term "various dressings" used in the above descriptions, refers to such well-known applications as Carbolic acid, Corrosive sublimate, Formaldehyde, Lysol, etc.—the well-known dressings for suppurative conditions. The most rapid results were noted in Cases 1, 2 and 6, but equally rapid results have been noted in many cases of like character which could not be herein mentioned owing to lack of space.

SOME AFFECTIONS OF THE LIVER REQUIRING SURGICAL TREATMENT.

W. LOUIS HARTMAN, M. D., SYRACUSE, N. Y.

My belief is, one is put to a test more often in making a diagnosis of morbid conditions of the liver, where surgical interference is necessary, than in any form of trouble arising in any other organ in the body. Ofttimes symptoms are entirely wanting, or are very vague, and then again they point to other parts of the body, or we may have symptoms which lead us to some other disease entirely foreign to that of the liver. So when we have a morbid condition of this very important organ it appears like a thief in the night, and

by the time we have awakened to the real danger our patient has made a goodly advance to that long slumber from which none ever awaken. Such may be the case in abscess, cancer and empyæma of the gall bladder.

In discussing the subject of surgery of the liver, it will be necessary to take the several diseases separately which call for surgical interference and begin with a diagnosis of the case. The first one I shall deal with will be that of empyæma of the gall bladder. I choose this first because so many troubles calling for surgical treatment may arise from this condition. This also is, at times, a morbid condition which is very obscure and misleading, as it may be mistaken for malaria, more especially in malarial districts. The most prominent symptoms of this disease are the chills, fever, and usually profuse perspiration following; but this is not always the case, as I have seen several cases where there was no perspiration following; however, if there is, it has a peculiar sweet and sickening odor. This is characteristic of any pus formation within this organ. Now, the difference between a chill and a fever of a malarial condition and that of pus in the liver or its adnexa is, in the former condition the chill usually appears with profound regularity and usually very marked, while that of the latter is decidedly irregular and may be from a marked chill to a slight sensation in the back, which in some cases will be so slight the patient will forget it or not refer to it at all, if you are not cautious and question them very closely. As a usual thing, we have sensitive condition over the region of the gall bladder, but this is not always present, as I will illustrate later on. It is always possible to have a tenderness in this same locality with malaria, but where there is pus existing the tenderness will be more marked and there will be an area of dullness existing over that locality. It may be the size of a small pear and it may extend down to the umbilicus, yes, even to the pelvic brim. In those cases it will be confounded with appendical troubles. The pain as a usual thing is not of a severe and lancinating character, but more often referred to as a dull pain or a heaviness. This organ may be so distended as to cause one to suspect a morbid condition of the colon, and even cause an obstruction of the bowel. This is more liable to arise, however, where the inflammatory condition has extended farther than the gall bladder of itself. This condition is nearly always brought about by gall stones becoming impacted and a source of irritation. Wherever we have a history of gall stones existing, and similar symptoms arise, it is always well to be on the alert for this condition. It is quite com-

mon to have digestive disturbances accompanying this malady. There will be loss of appetite, tongue heavily coated and thick and flabby, with imprints of the teeth on the sides; patient will complain of a dull feeling, sleepiness, constipation, and stools are usually of a dark color. If the abscess is discharging into the bowel, we may have diarrhœa instead, and ashy appearance of the skin with drawn features. Clay-colored stools would be one of the first things we would look for, but unless there is pressure exerted on the ductus communis or causing an obstruction we would not have this condition.

Now, we must not think for a moment it is necessary to have a history of gall stone colic in order to have gall stones of sufficient size to cause this trouble, as I have seen gall stones nearly the size of a hen's egg without ever being able to obtain a history of colic. The following case will go to illustrate this very nicely:

I was called in consultation to Mrs. Q., aged forty-two, who had suffered for several years with indigestion, both stomach and intestinal. Her greatest trouble was the inability to digest starchy foods; had immense accumulations of gas, both in stomach and intestines, and was decidedly constipated. She never had an attack of gall stone colic, but for seven or eight days prior to seeing her she had been troubled with the above stomach and intestinal disorders. She had been suffering no pain during her recent illness, which had dated back about one week; her appetite had been fair; that is, she wanted the food, but the stomach was unable to handle it. The reason I was called in was they feared an obstruction of the bowels, as they had been three days trying to get a movement with purgatives and enemas without result. They had also discovered the dullness in the right side extending from the point of the tenth rib down to about an inch below the umbilicus. In this case I was a long time obtaining a history of chill. She had only experienced one, and that was so slight she had not considered it as such. My diagnosis was empyæma of the gall bladder. I sent her to the hospital, and the next morning opened the abdomen and verified my diagnosis. I found the gall-bladder enormously distended with pus and gall-stones, of which latter I removed twenty-six. There had been entire obliteration of the passage into the ductus communis. The patient made an uninterrupted recovery and was relieved of all her former stomach and intestinal disturbances.

Now, an empyema of the gall-bladder may cause secondary abscess of the liver in some remote part; also, we may have infection

going through the walls and producing abscess on the outside, or septic peritonitis may follow.

The subject of abscess of the liver as put down in the text books is very misleading, as one is led to believe the majority of cases are found in the hot climates and that in this climate we find very few; but as you will see, the causes which produce abscess of this organ are more common than is naturally supposed. In the first place, localized inflammation of the liver due to traumatism may produce this affection, more especially in children after receiving a severe fall. Then again a punctured wound is very liable to produce abscess, more so than an external blow, and more especially in the adult. In children the external injury is equal to that of a puncture in the adult. We must not overlook the fact that people who have resided in hot countries and then come to the colder climates are quite as liable to this affection as people who continually reside there. You will find the pus in the abscess produced in hot climates of a red nature, while the contents of those produced by other causes is much different. Foreign substances which have been taken into the stomach, such as fish bones, pins, etc., are liable to work themselves into the liver and produce abscess, but the abscess does not usually follow immediately; it may take place some months after the foreign substance has been swallowed.

Undescended gall-stones may produce this malady when they have lodged in the inner ducts of the liver, increased in size and produced an irritation.

Bacterium coli commune is a leading factor. This, of course, is produced from the bacterium working its way up the ductus communis and depositing the infectious material within the body of the liver.

Pyæmia is a prime factor, and does not produce a single abscess but several of them. When we have this condition there is practically no relief to be obtained through surgical interference.

Intestinal parasites have been known in a number of cases to produce abscess of this organ. They enter in the same way as the bacillus coli communis. They are liable to reach far up into the body of the same; but they very soon die, as bile is poisonous to them, more especially the round worms. This variety may be single or multiple, it depends upon the number of parasites which have entered the liver.

Hydatid cyst may also cause this disease. Where we find this we

find the parasite in a bed of pus. This is of rare occurrence, and is usually found in foreign subjects, of which I will speak later on.

Empyema of the base of the right lung is a very important factor, as the inflammatory condition extends and the septic matter pushes its way through the pleura and affects the liver.

Tubercular cavity of the right lung may be one of the causes, but when this occurs you will find it in the upper portion of the liver. In these cases the pus cavities will become connected and there will be but one pocket.

One must not forget this disease when they have a puerperal septicæmia, where apparently the local trouble has subsided and we continue to have chill and temperature; in fact, the whole train of the septic condition. In these cases it will be well to examine the liver closely where we have this condition following.

Dysenteric ulcers of the large intestines are frequent causes, more especially where they are of severe and deep variety. This, however, may not follow immediately, but the patient will not regain health.

Diagnosis.—The pain which usually manifests itself is localized in the right hypochondrium, extending into the right shoulder. This symptom of pain extending into the right shoulder is not to be taken as a guide, as this is wanting in as many cases as you will find it present; therefore, an explanation becomes necessary in order not to make it misleading.

Muddiness of the complexion is a symptom nearly always present in connection with a flabby tongue and thick coating, which may be from a white to a dark gray, with imprints of teeth.

Jaundice is a symptom frequently found, but this depends wholly upon the location of the abscess. If the abscess is located where it will exert pressure on the ductus communis choledochus, jaundice will be present; but if in some remote locality, it may be slight or even wanting. This condition is most common in the pyæmic variety; in fact, jaundice, either slight or marked, is seldom, if ever, absent.

Naturally, we would place a great deal of dependence upon the size of the liver, and expect to find it enlarged to a great extent. This, however, is not always the case. If the abscess is located in the upper and posterior portion, it will not be so perceptible as when in the lower part.

Dysentery is one of the symptoms which is wanting as many times as it is present, but when we find this condition it is of great significance.

We must not mistake local peri-hepatitis for abscess. This can be distinguished by a pronounced friction sound.

Chill and temperature are always present, also the peculiar perspiration I have heretofore mentioned. As I have said before, we must not expect to find the former running with any regularity. I think the temperature in this malady is the most misleading of any inflammatory or septic condition, as there is absolutely no regularity and it may be from ninety-nine to one hundred and five or six. If the abscess is located in the upper portion, cough with expectoration of glairy mucus is present.

Emaciation is quite a prominent symptom where the suppurative process does not make rapid progress.

The treatments of empyæma of the gall bladder and abscess of the liver are similar, so I will take them up under one head. After the abscess is located in either condition, if it is possible to locate it in the latter, the first thing to do is to liberate its contents. Do not allow nature to do this as it often does, as it is just as liable to liberate itself in the abdominal cavity and bathe the intestines, and, of course, it is not necessary for me to tell you the termination.

The aspirating needle is a valuable aid to the diagnosis, yet, I may say the paramount instrument; but let me say right here a word of warning regarding the use of the same, it is not as most men believe an innocent procedure to put an aspirating needle into the liver. It is possible to lacerate this organ to quite an extent with this instrument; and then, again, the affected portion may not be, as it seems from the exterior, adhered to the abdominal parietes. So it is always quite necessary in using the aspirating needle to be prepared to open the abdomen at once, either to repair a laceration or extricate pus from the peritoneal cavity.

In operating for empyæma of the gall bladder, if it is possible, and there are no adhesions to the abdominal parietes, stitch the walls of the bladder to the parietes, or pack sponges around carefully, thereby walling off the parietal cavity to prevent infection before the bladder is opened and pus liberated. The same, of course, should be done with abscess; but at times it is not expedient to attach the liver to the parietes, therefore we must wall it off best we can with gauze. When the cavities have been opened, they should be washed out with a saline solution and a good-sized drainage tube put in. It is not wise to pack them with gauze, as gauze does not drain out pus as well as a drainage tube.

The trochar should never be used in exploring the liver unless the abdomen has been opened previously.

Hydatids of the liver are of rare occurrence. They are, as a usual thing, found in people who reside or have resided in hot climates. You will find them more often in foreigners. The only guide we have to go by in making a diagnosis is the enlargement, as other symptoms are almost always wanting, unless the tumor should be located in that region of the liver which would cause an obstruction of the gall bladder or the ductus communis choledochus, in which case we would get jaundice. Hydatids are, as a rule, of quite rapid growth. There is but one treatment for them, and that is surgical. Open the abdomen and, if it is possible, dissect out the tumor; if not, drain off its contents, stitch the walls to the abdominal parietes, pack lightly with gauze and allow to heal by granulation. The gauze should be removed every other day, and be very cautious not to pack too tightly, putting in a less quantity of gauze each time the wound is dressed. These cases are tedious, and you will come to the conclusion that the hole never will fill up. If the hydatid is so situated that you can take it out by removing a part of the liver, you are justified in so doing, as quite a portion of the liver can be removed without doing any great harm. Experiments upon cats and dogs have shown that three-fourths of the liver may be removed and produce no serious results. Meister finds that not only can two-thirds of the liver be removed without serious consequence, but regeneration also takes place. After removing three-fourths of the liver, regeneration was so rapid it regained its normal weight in thirty-six days; but, really, I would not care to remove three-fourths of the liver of a human being, as I would expect after so doing it would be but a short time before he would have neither pulse nor temperature and his troubles with that organ, as well as all others, would cease.

Stab wounds and rupture of the liver are things which should be thoroughly understood, as these cases often come to the hands of physicians who are unprepared to deal with them. In a stab wound, the opening into the abdominal parietes must be enlarged at once and the hæmorrhage from wound in liver controlled either with forceps and ligatures or wound firmly packed with gauze. If possible, the wound should be sutured at once.

This, of itself, will usually control hæmorrhage. If a rupture of the liver is suspected, in which case we get symptoms of internal hæmorrhage, the first thing to do is to make a laparotomy. In suturing the liver, a material of absorbable nature should be used. Of

course, cat-gut is the only material, and the ordinary gut is absorbed too quickly, therefore the chromicised variety is preferable. Do not use too large a size, the smaller size will last long enough to heal any ordinary wound. The round needle should be used, not the Hagedorn, nor any one which has cutting edges, as they produce oozing. The round needle will penetrate this tissue very easily, and in tying these sutures pay strict attention that you do not pull them so tight as to lacerate, as in using the round needle this is one of the things we try to prevent.

A CASE OF DYNAMIC ILEUS.

J. L. PECK, M. S., M. D., SCRANTON.

Two weeks ago I was called to see a patient whose case has proved of more than usual interest. The history is as follows: Female, married, age twenty-six, family history negative, personal history good until one year ago, at which time she was delivered of a child by a midwife. Two days after delivery she began to suffer from severe pains in the pelvis and a physician was summoned. On the tenth day she attempted to get up, but weakness prevented. She remained in bed for three months suffering from what her physicians told her was "blood poisoning." Before the expiration of this time she developed vesical irritation, which resulted in a very annoying and painful condition, and from that time until her late acute attack was treated by eight different physicians for the relief of these tormenting vesical pains. Bladder washes, internal and external medication, including elixirs, emulsions, infusions, mixtures, cathartics, sedatives, tonics, pills, capsules, suppositories of opium until she was taking three or four daily and had become a confirmed opium habitue, surgical and other methods advised and accepted or rejected according to the discretion of the patient and her ability to endure the treatment, all proved fruitless and her plump and healthy physique was reduced to a living skeleton.

Two weeks ago when, as I have said, I first saw her, I learned on inquiry that four days previous she had experienced some pain in the abdominal region, and thinking it due to an "aching void" she decided to indulge in a hearty meal, boiled green corn constituting a favorite part of the menu. Immediately after severe abdominal pain developed, and she summoned her physician, who at once administered a hypodermic of morphine and a rectal suppository of

opium. This treatment lulled the pain temporarily, but as soon as the effect of the opiates passed off her suffering returned with increasing intensity, accompanied by violent vomiting. Cathartics, opiates and low rectal enemata were used persistently without results. On examination, I found decided distention and considerable tenderness over the entire abdomen. By this time fæcal vomiting was pronounced. The inflated coils of intestines caused considerable bulging about the umbilicus, which led her physician to diagnose strangulated umbilical hernia. I did not concur in this diagnosis, and advised immediate removal to the hospital. Her prostration was much greater than would be indicated by a rise in temperature of one degree and pulse of 110. Her exhaustion was so great that she could not speak above a whisper.

For the next twelve hours we endeavored to melt away the obstruction by castor oil per oram, and oil, turpentine, compound and saline enemata through a 30-inch rectal tube, assuming at the same time all the available postures in the treatment of ileus, but without results. She was passing no gas. The family were opposed to surgical interference, but there being no alternative an operation was resorted to at once as the only possible means to save the patient's life. On opening the abdomen I found about fifteen inches of the lower ileum collapsed, or in a state of spasmodic construction. This portion of the ileum was not larger than my little finger, the lumen of the bowel being almost completely occluded. The intestines anterior to the constriction were ballooned, and the entire intestines were of a dark purple color. After thorough exposure and careful inspection, the intestines were replaced, and the abdominal wound closed, and the patient was back in her bed within twenty minutes after the operation was begun. She reacted slowly, but well, considering her condition. Temperature, 96.6°; pulse, 115; respirations, 24. Severe pain and restlessness followed for about ten hours, when, contrary to our custom, we yielded to her supplications and allowed her to be turned on her side. Within ten minutes afterwards she went to sleep, and rested quietly the remainder of the night. From that time she has had very little pain and no vomiting.

Eighteen hours after operation one-fifth grain of Calomel every hour and Plumbum 6x were prescribed. Forty-eight hours after operation a high turpentine enema was given, resulting in a small-sized, soft, semi-formed brown bowel movement, with considerable gas. Seven hours later she had a small fæcal movement, and since that time has had one or two small or medium-sized formed, or partially formed, bowel movements daily.

Six hours after operation we began giving the patient one-half ounce of hot water every half hour, gradually increasing the quantity. Sixteen hours after operation one drachm of liquid peptonoids was given every two hours. Thirty-six hours after operation nutritive enemata of malted milk, 4 ounces, and perfection liquid food, ½ ounce, with a little salt added, were ordered every six hours, and continued for three days. Hot broths by mouth were also given in small quantities. On the fifth day a diet of malted milk, broths and perfection liquid food was allowed. On the sixth day gruels and softened toast were added to the dietary, and on the seventh day the regulation low diet of the hospital, gradually increasing to medium and full diet.

On the tenth day every second stitch was removed, and the remainder two days later. Union was by first intention. At the present time the patient is improving rapidly, appetite good, bowels moving regularly without aid, and has no complaints with the exception of her old bladder irritation, which has been less troublesome since her operation.

Cases of dynamic ileus are rare. By reading the few reported cases, we find that it may result from a variety of causes, such as lead poisoning, ptomaine intoxication, milk, ice cream, cheese, and shell fish. The lesion present is a tonic contraction of the circular muscular fibres of the intestine. Our present case has been a morphine habitue for nearly a year. This drug, as we know, exerts a prohibitory action over intestinal peristalsis and a tendency to paralysis and relaxation instead of contraction of the muscular fibres. In my opinion dynamic ileus in this case was due to ptomaine poisoning resulting from the decomposition of over-ripe corn in combination with other articles of food.

With the rapid progress this patient was making toward a state of collapse there is no doubt but that death would have followed in a very short time had we not resorted to speedy operation. I believe that the act of opening the abdomen, exposing and manipulating the intestines, relaxed the spasm of the circular muscular fibres, stimulated peristalsis, and saved the life of our patient.

DISCUSSION.

Dr. H. L. Northrop: I merely wish to record a case I operated on, a case of tonic contraction of the circular muscular fibres of the ileum a distance of two feet. The opening of the abdominal cavity and closure was followed by prompt and speedy recovery.

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